DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

MEDICAID PROGRAM
DEMONSTRATION PROJECT:
COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Invitation to Apply for
FY2007 DEMONSTRATION PROJECT GRANT
CFDA 93.789

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PART ONE: OVERVIEW INFORMATION

Department of Health and Human Services
Centers for Medicare & Medicaid Services

MEDICAID PROGRAM
DEMONSTRATION PROJECT:
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PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Initial Announcement

Invitation to Apply for FY 2007 - **DEMONSTRATION PROJECT: COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES**

Agency Funding Opportunity Numbers

HHS-2007-CMS-PRTF-0002

CFDA 93-789

July 7, 2006

Applicable Dates:

Applicants' Informational Teleconference:	September 19, 2006
Voluntary Notice of Intent to Apply:	September 8, 2006
Grant Application Due Date:	October 18, 2006
Issuance of Notice of Grant Awards:	November 24, 2006
Grant Period Start Date:	December 1, 2006

Demonstration Grant Period of Performance/Budget Period:
October 1, 2006 to September 30, 2011

For more details and news about events relevant to this and other related grant opportunities, please periodically consult our Web site at www.grants.gov.
http://www.cms.hhs.gov/NewFreedomInitiative/02_WhatsNew.asp

This information collection requirement is subject to the Paperwork Reduction Act. The burden for this collection requirement is currently approved under the Office of Management and Budget control number 0938-0836 with a current expiration date of January 31, 2007.

PART TWO: FULL TEXT OF THE ANNOUNCEMENT

I. FUNDING OPPORTUNITY DESCRIPTION

1. Background and Introduction

- **Introduction**

The Deficit Reduction Act of 2005 (DRA), section 6063, establishes a grant demonstration program; Community-Based Alternatives to Psychiatric Residential Treatment Facilities (PRTFs). This Grant Solicitation provides a full description of the funding opportunity, eligibility and award information necessary to help States provide home and community-based interventions to youth eligible for PRTF level of care. A detailed description of the fundamentals of the demonstration, including the goal of the demonstration, definitions, design, and development information are found in Section I, 2 of the solicitation. Application and submission requirements can be located in Section IV, and comprehensive review criteria for award are found in Section V.

The Application submission will include a systems assessment, demonstration design, and Financial Neutrality Form, following the application instructions in Section IV. Through a competitive process, up to 10 applications will receive awards. The States receiving awards will be required to submit an Implementation Plan. States receiving an award under this solicitation will have nine months to complete the Implementation Plan for the Centers for Medicare & Medicaid Services (CMS) review and approval.

- **Background**

The New Freedom Initiative (NFI) announced by President Bush on February 1, 2001, is part of a nationwide effort to remove barriers to community living for people with disabilities. It represents an important step towards ensuring that all Americans have the opportunity to learn and develop skills, engage in productive work, and choose where to live and participate in community life. NFI goals include: increasing access to assistive and universally designed technologies; expanding educational opportunities; promoting homeownership; integrating Americans with disabilities into the workforce; expanding transportation options; and promoting full access to community life.

The New Freedom Commission on Mental Health (the Commission), created on April 29, 2002, as part of the NFI, was charged with making recommendations to the President that would enable adults with serious mental illnesses and youth with serious emotional disturbances to live, work, learn, and participate fully in the their communities.

On July 26, 2003, the Commission released its final report, *Achieving the Promise: Transforming Mental HealthCare in America.* The final report outlined significant problems associated with providing community-based alternatives to youth with serious emotional disturbances. Youth and families typically have little influence over decisions affecting service delivery, planning, and the use of financing to deliver care. When comprehensive community-based options are not available youth are often placed in out-of-State facilities. Additionally, a recent General Accounting Office study on child welfare and juvenile justice

documented, in a survey with 19 States and 30 counties that, in 2001, parents placed over 12,700 youth into the child welfare or juvenile justice systems so that they could receive mental health services. This sobering finding is nonetheless a significantly low estimate, as 32 States did not respond to this survey.

The Commission's final report sought to help remedy these problems by specifically recommending that a demonstration be conducted in order to allow CMS to develop reliable cost and utilization data to evaluate the impact of Medicaid waiver services on the effectiveness of community placements for youth with serious emotional disturbances in PRTFs. Systems of care and wraparound are specifically cited as effective community-based models that can help reduce placement in institutional settings.

Over the last decade, PRTFs have become the primary provider for youth with serious emotional disturbances requiring an institutional level of care. However, since they are not recognized as hospitals, nursing facilities or intermediate care facilities for the mentally retarded, many States have been unable to use the 1915(c) waiver authority to provide home and community-based alternatives to care, which would keep the youth in their homes and with their families.

Section 6063 of the DRA addresses this issue by providing up to $218 million to up to 10 States to develop demonstration programs that provide home and community-based services to youth as alternatives to PRTFs. CMS anticipates awarding each successful applicant between $21.7 and $50 million. The PRTF Demonstration is authorized for up to 5 years. Payments may not be made to States after fiscal year 2011. CMS will review and approve each State's Implementation Plan prior to allowing States to access funds for Federal reimbursement of services under this grant. Section 6063 also provides $1 million for a National Demonstration Evaluation.

PRTFs are defined as any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21 (42 CFR §441.150 - §441.182). The facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or any other accrediting organization with comparable standards recognized by the State. Additionally PRTFs must comply with Conditions of Participation on the use of restraint and seclusion (42 CFR §483.350 - §483.376).

For purposes of the demonstration, PRTFs will be deemed to be facilities specified in section 1915(c) of the Social Security Act (in addition to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded). The demonstration may target youth who are not otherwise eligible for any Medicaid-funded, community-based services or supports.

At the conclusion of the demonstration programs, States will have the option of continuing to provide home and community-based alternatives to PRTFs for participants in the demonstration under a 1915(c) waiver, as modified by the provisions of this demonstration.

2. Overview of Funding

Fundamentals of the Demonstration

Goal

The goal of this Demonstration Grant Program is to test the effectiveness in improving or maintaining a child's functional level and the cost effectiveness of providing coverage of home and community-based service alternatives to PRTFs for youth enrolled in the Medicaid program under title XIX.

A. Problem Statement and Systems Assessment

This demonstration requires that States define the problem(s) that prevent the target population(s) from receiving comprehensive, integrated home and community-based services. States should thoroughly understand the following systems level considerations:

- The population(s) to be served, including any geographic variation in key population characteristics. Of particular importance are the incidence and prevalence of mental and physical health needs of the population.
- The need for the demonstration in the geographic area(s) where community-based services are to be provided.
- The comprehensive systems assessment approach to be employed as mechanisms for developing their demonstration projects. At a minimum, systems integration goals must include mental health services (Medicaid and non-Medicaid funded), child welfare, substance abuse, schools, juvenile justice, and physical health care.
- The cultural diversity in the geographic area to be served. States must understand the culturally appropriate interventions to ensure that youth from various cultural backgrounds will receive appropriate culturally sensitive interventions.

B. Demonstration Design and Development

This demonstration permits States to offer home and community-based services to individuals who: (a) are found to require a PRTF level of institutional care under the State plan (this also includes youth who are in an out-of-State PRTF placement); (b) are members of a target group that is included in the demonstration; (c) meet applicable Medicaid financial eligibility criteria; (d) require one or more demonstration service in order to function in the community; and, (e) exercise freedom of choice by choosing to enter the demonstration program in lieu of receiving institutional care.

The CMS will provide preference to States who significantly include youth and their families as participants in the design, development, implementation, and ongoing review of the project. Stakeholder participation can take the form of an advisory council, steering committee, or other mechanism that ensures timely and relevant input from participants and families throughout the life of the grant.

Under this demonstration, States are granted the same waiver provisions provided to States who operate a section 1915(c) waiver program. The three waiver provisions of title XIX of the Social Security Act (the Act) are as follows:

§ 1902(a)(10)(B) (Comparability) The waiver of this provision of the Act permits a State to limit the provision of waiver services to Medicaid beneficiaries who require the level of care in an institutional setting, are in the target group(s) specified in the waiver, and offer services to waiver participants that are not provided to other Medicaid beneficiaries.

§1902(a)(1) (State-wideness). The Secretary may grant a waiver of this provision of the Act in order to permit a State to limit the operation of a waiver to specified geographic areas of the State; and,

§1902(a)(10)(C)(i)(III) (Income and Resources for the Medically Needy). A State may request a waiver of this provision in order to apply institutional income and resources rules for the medically needy to persons in the community who otherwise qualify for waiver services.

Additionally, States' program design under this demonstration shall comply with existing Medicaid statutory and regulatory requirements governing the administration and operation of a section 1915(c) waiver program, especially the six statutory assurances that are located at 42 CFR §441.302.

Applicants are encouraged to facilitate the provision of services in home-based settings where the participants live with their family, in their own private residence, or in a living arrangement where services are furnished to fewer than four persons unrelated to the proprietor. In situations where services will be provided to people living in facilities that house four or more people who are unrelated to the provider (regardless of whether such individuals receive demonstration services), applicants must describe how a home and community character is maintained.

A "home and community character" includes describing how the facility is community-based, provides an environment that is like a home, provides full access to typical facilities in a home (such as a kitchen with cooking facilities, small dining areas), provides for privacy, and provides easy access to resources and activities in the community. Demonstration services should not be provided in institution-like settings except when such settings are employed to furnish short-term respite to individuals.

Services in a PRTF are provided to individuals who are at an institutional level of care and such services must be a benefit under the State plan. States must ensure that such facilities comply with Federal statutory and regulatory specifications related to PRTFs at 42 CFR §440.160, § 441.151-152, and §483.352-.376. States that purchase the PRTF benefit from other State(s) are considered to be operating such a benefit under their State plan and are eligible for participation in this demonstration. As a part of a State's application to this

demonstration, the State shall submit a copy of the pre-print page(s) indicating that such benefit is covered under the State's Medical Assistance Plan.

C. Participant Recruitment

In its application, a State must specify the group or groups of Medicaid beneficiaries who will be served under this demonstration. Specifically, will the State use this demonstration to divert youth from admissions to a PRTF and/or use this demonstration to transition such individuals from PRTFs into the community?

The level of care for Medicaid eligible individuals for this demonstration, at a minimum must be under the age of 21 and require the need for a PRTF as defined in the State's Medicaid State Plan. For the purposes of this demonstration, **youth** are defined as "any child, adolescent or young adult under the age of 21." States shall ensure that each participant under the demonstration meets this level of care criterion to participate in the demonstration. Further, States may elect to add additional criteria to carve out, or target, a specific sub-population to receive home and community-based services under this demonstration. As a part of the application process, States shall submit a copy of the level of care assessment used to assess eligibility for participation in this demonstration.

D. Interventions

Introduction:
States must provide an array of mental health and medical assistance services appropriate to the needs of youth meeting PRTF level of care. States have flexibility in determining the types of services that they will provide to demonstration participants. States may provide services currently offered under the State plan and any "other service(s)" which the State can demonstrate would be required for care and treatment otherwise provided in a PRTF. Services in the "other" category should be supported by research-based evidence, of their effectiveness. However, in the absence of such evidence CMS will consider funding for non-traditional services. States must agree to perform an evaluation that addresses the efficacy and cost effectiveness of proposed non-traditional services. CMS retains the authority to attest to whether or not the provision of such "other services" prevents the likelihood that demonstration participants will be placed into a PRTF.

Consideration of Service Delivery Approaches

- Systems of Care: States should include in the demonstration design systems of care efforts sufficient to ensure that youth served under the demonstration have access to coordinated, non-duplicative services and supports in their home communities. A system' of care approach will ensure that communities have well-developed collaborative working arrangements among the multiple systems that youth may be involved in. Collaborations should include, at a minimum, mental health providers, the school system, the child welfare system, and the juvenile justice system. Systems may include housing, substance abuse services, and others. Youth served under the demonstration should have access to an integrated, seamless, culturally competent system that is driven by the consumer and family and provides an array of services

and supports to meet the complex needs of this population. See Attachment 4 for additional information on systems of care.

- Cultural competence: Cultural and linguistic knowledge should be an ongoing developmental process at all levels of the service delivery system. Services should be delivered according to the cultural preferences and needs of families.

- Strengths-based planning and service delivery: States should consider delivering services that are focused on strengths, interests, abilities and capabilities, rather than deficits, weaknesses, or problems. The assumption is that the child and family are the experts in their lives and that they, rather than the professional, direct the helping process. All people involved have the capacity to learn, grow, and change. Friends, neighbors, and others in the community are seen as potential resources to assist and support the individual and family.

- Wraparound: For purposes of this demonstration, CMS defines "wraparound" as an approach to the development and delivery of individualized, comprehensive services within a system of care for youth with complicated multi-dimensional problems. States should develop an effective wraparound approach that includes the following components:
    i. Strengths-based assessment, planning and service delivery.
    ii. Child and family teams: A child and family team is composed of people who play a meaningful role in the life of the child and family. Membership is driven by the child and family rather than professionals. Meetings are held at the time and place convenient to the family.
    iii. Cross-agency community team: Community teams are comprised of community stakeholders who work collaboratively to ensure that adequate community level system integration occurs and to ensure that participants have access to non-traditional services and supports, and flexible funding. Community stakeholders must include family members and/or someone meaningful to the child.
    iv. Flexible funding: Families need access to non-categorical funding for services, supports, and goods needed to reach goals, but not covered under traditional sources.

- Self-Direction: States should consider a self-directed program approach. CMS defines a self-directed program as "a State Medicaid program that presents individuals with the option to control and direct Medicaid funds identified in an individual budget." CMS requirements for a comprehensive self-directed program include:
    i. Person-centered planning: A process, directed by the participant, intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the participant.
    ii. Individual budgeting: The total dollar value of the services and supports, as specified in the plan of care, under the control and direction of the program participant.

iii. Self-directed services and supports: A system of activities that assist the participant to develop, implement, and manage the support services identified in his/her individual budget.
iv. Quality assurance and quality improvement (QA/QI): The QA/QI model will build on the existing foundation, formally introduced under the CMS Quality Framework, of discovery, remediation, and continuous improvement.

Service Considerations

The State should include a detailed list and description of the demonstration and medical assistance services that will be provided to youth who will be cared for in the community in lieu of PRTF services under this demonstration project. The list of services should be based on satisfying the following therapeutic functions and supports for these individuals and must comply with the Medicaid home and community-based services requirements at 42 CFR 440.180 for not only the statutorily authorized services but also for any other services for which it can be demonstrated that the service in necessary to assist a demonstration participant to avoid institutionalization and function in the community. In addition, the demonstration program of services must meet the standards specified at 42 CFR 441.302 concerning the best interests of the youth, including health and welfare assurances. The services under this demonstration program should be coordinated with services provided through other funding streams (e.g., juvenile justice, foster care, etc.). This demonstration is meant to provide better care and expanded coverage to youth in PRTFs, or in PRTF jeopardy, and not for shifting costs from other programs or for supplanting services paid through other established funding streams.

Therapeutic Functions and Supports

- Screening & Assessment (Diagnosis)
  Evaluation and assessment services for each individual should be provided to assess physical, emotional, behavioral, social, recreational, educational, legal, vocational, and nutritional needs.

- Treatment and Treatment Planning for the Individual
  This includes services tailored to the age groups and other relevant characteristics of the specific child or youth population which are necessary to meet the daily living needs as determined in the screening and assessment process. It also includes services specific to a treatment planning process and a periodic review of the therapies which would enhance the child's or youth's treatment and care through an ongoing assessment of important aspects of the individual's care and the correction of identified problems, thereby assuring the quality of care and quality improvement. Planning services for demonstration program discharge and aftercare (including the coordination with other therapeutic programs), and for crisis or emergency situations, should also be included.

- Participant-Centered Planning and Participant Direction of Services
  States should develop a process which affords demonstration participants the opportunity to be involved in the development of his/her plan of care. In this process, demonstration participants would be able to exercise choice and control

over services and support. States should afford all demonstration participants the opportunity to direct some or all of their demonstration services. In this process, risks should be assessed and planned for (risk mitigation). States are advised to refer to appendices D and E in the instructions for the Home and Community Based Services (HCBS) demonstration application.

- Training
  Provider training on how to manage behavior issues in accordance with the child's or youth's individualized treatment plans, including an array of interventions that are alternatives to seclusion and restraint should be included in the demonstration.

- External stakeholder involvement
  The demonstration should create linkages by which all demonstration participants can be involved in community activities, organizations, and events (e.g., school systems in the individual's service area), thereby providing for environmental normalization for the child or youth. The demonstration should also include a process whereby advocacy and special interest groups can be involved in the demonstration program and, more specifically, with individual demonstration participants.

- Education and Vocational services
  These services should be age appropriate and in accordance with the individualized treatment plan. Grant monies may not be used to pay for special education and related services that are included in a child's Individualized Educational Plan (IEP) that must be furnished to a child under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA). In addition, vocational services may only be furnished under the demonstration program to the extent that they are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973. States are advised to refer to appendix C of the instructions for the HCBS demonstration application.

- Activity services
  Recreational and social activities should be incorporated in the plan of care for the demonstration participant.

- Social Skills training
  The demonstration should include social skills training to enhance the children's age appropriate skills necessary for the children to self care and to function effectively in the community. The demonstration should also focus on transitioning individuals out of the demonstration program, when they are ready, by providing life training services that will help the children to become independent.

- Support Services
  The demonstration should provide services which would provide support not only to the demonstration participant but also to his/her family. Such services may

include respite care, family counseling, family-to-family peer support, and others. States should include as an important element of the demonstration a description of any other wraparound services from other agencies, even though these services would not be reimbursable under the demonstration program.

- **Examples of Potential Enrollees**

  The following are hypothetical examples of individuals and how they might benefit from this demonstration:

  a. Brent is a 16-year-old boy who loves fishing and music but was having a very difficult time in school and at home and was increasingly experiencing legal troubles. He was diagnosed with paranoid schizophrenia when he was 16, and the stress of living with hearing voices and disorganized thinking resulted in complete social withdrawal. Brent was failing school and abusing drugs as well.

     Brent's mom, Cindy, tried to enroll him into the local mental health program. However, because of funding shortages, she could not get an appointment for 3 weeks. Additionally, the crisis worker at the access center implied that if only Cindy did not provoke Brent so much he may not have so many problems. After Brent physically attacked her again Cindy called the police and pressed charges, no longer feeling safe with Brent in the home. This resulted in a court ordered placement of Brent in a Medicaid covered, out-of-State PRTF.

     During Brent's year long stay in the PRTF, his home community developed community-based mental health services that provided intensive home-based case management services, family therapy, and psychiatric services. Brent and Cindy agreed that Brent would slowly transition out of the PRTF by first going home on weekends, leading to permanency at home. Brent and Cindy experienced a very different system than the one that existed prior to Brent going into the PRTF. During the initial contact with the receptionist, they were given the opportunity to interview several case managers to help find one that Brent and Cindy were comfortable with. After several interviews, they settled on Joe, who Brent got along with very well. Cindy also found Joe to be very respectful. Joe approached Brent and Cindy as equal partners in finding workable solutions to their problems. He did not blame her for Brent's problems, as the earlier access worker had done, but instead pointed out several areas where she and Brent had been very successful in creating solutions themselves. Brent and Cindy felt that, at last, they have found someone who could help Brent get effective assistance in finding his way in life.

  b. Jan is a 12-year-old girl who has above-average intelligence and was confined to a PRTF after inability to concentrate and refusal to go to school as a result of repeated physical and sexual abuse by her estranged biological father. She was diagnosed with post-traumatic stress disorder, major depression, and hyperactivity-attention deficit disorder. Jan was served by several agencies in the

community before being admitted to the PRTF, including community mental health, juvenile justice, child welfare, and special education.

While Jan was in the PRTF, her home community developed a collaborative wraparound process that included a community team composed of representatives from systems listed above, wraparound facilitators, child and family driven care plans and a flexible funding pool based on contributions from all members of the community team. Jan and her family agreed to participate in the wraparound process as an alternative to the child and family team development process was implemented as part of discharge planning. The planning process included integrating school-based services, Medicaid funded home and community-based services, and child welfare services.

In addition to the services provided through various agencies, the flexible funding pool was able to fund art supplies, painting classes, and one-on-one art tutoring to help Jan reach her personal goal of expressing herself through painting. Additionally, Jan's mother agreed to work with a parent-peer who formed a support group for family members dealing with troubled youth as a result of her wraparound experience. She ultimately joined the wraparound community team as a parent advocate. Jan also agreed to work with Marie, a peer support person who graduated from wraparound and wanted to help other youth in the program. Marie provided Jan with practical counseling that helped her develop useful strategies to deal with her stress and pain, greatly assisting her in successfully integrating back to school. The two have developed a lasting friendship.

After many months of working together, Jan graduated from the formal wraparound process, but she and her family continue to employ wraparound principles in their lives through child and family team planning with the school system and community mental health which continue to provide support for Jan to help her reach her goals.

c. Miguel, at 15, is the oldest of three boys living with their mother, Gitana, who is single and working two jobs to make ends meet. Miguel, a star athlete at school, began having serious emotional difficulties, feeling extremely anxious, not sleeping, and playing loud music at all hours of the night. One morning Gitana woke to find that Miguel had been up all night. Miguel was extremely agitated and expressing delusional thoughts that people where living in the basement and tracking his thoughts. Gitana was able to help him calm down enough and go to see a local curandero, a traditional healer who was also a family friend. While the curandero was able to help Miguel, he continued to have problems. After several incidents similar to the one described above Gitana decided to bring Miguel to the emergency room. Miguel was diagnosed with schizophrenia and admitted to the inpatient unit for a 72 hour observation.

While in the hospital the case manager offered Miguel and Gitana the opportunity to engage in an alternative community-based program. The program included an

option for a self-directed individual budget to help Miguel live at home. Miguel and Gitana decided to pursue the self-directed option and engaged in strengths-based person centered planning to assist them in deciding what services and supports Miguel needed. The budget included Medicaid funding, as well as other sources of monetary support. The planning process was facilitated by a support coordinator from the community mental health center and included a case manager, Miguel's probation officer, a social worker from school, his social worker from the hospital, his close friend Carlos, the curandero and Miguel's family. The meetings were held at Miguel's house in the evening after Gitana got home from work.

The team ultimately decided to allocate their budget across a variety of innovative services and supports including peer support services for Miguel, home based family therapy, curandero services, and personal assistance to help Miguel stay focused after school. Miguel engaged in traditional psychiatric services at a local mental health clinic and participated in a group therapy model to help kids with serious emotional disturbances.

Miguel and Gitana interviewed several peer support specialists who were former participants in self-direction and wraparound before settling on Joe. Joe agreed to become an employee of Gitana with the help of a financial management service to pay for the service and help manage the overall budget.

E. Systems Quality

While it is important for the demonstration to include services that will improve the quality of care provided to the child or youth, it is also important for the demonstration to develop a system (or processes) to review findings from discovery activities and to use these findings to establish priorities and to develop strategies for remediation and improvement of the demonstration. The demonstration design should include a description of how quality management information is compiled and how frequently this information is communicated to waiver participants, families, service providers, other interested parties, and the public. States are advised to refer to Section IV, 2 for the Form of the application submission, and Appendix H in the Instruction for the HCBS waiver application for more detailed guidance on this subject found at: http://www.cms.hhs.gov/HCBS/02_QualityToolkit.asp#TopOfPage.

F. Provider Requirements

In the demonstration design narrative, States must provide a statement of assurance that necessary safeguards have been taken to protect the health and welfare of youth receiving home and community-based waiver services under this demonstration project. In the Implementation Plan, States will be required to provide documentation for these safeguards (i.e., that adequate standards for all types of providers that provide services under the waiver have been established and are being met; and that the standard of any State licensure or certification requirements are met for services or for providers furnishing services under the waiver.) All providers must be certified under the Medicaid program and have been issued a

provider number. These providers must co-operate with participant-centered planning and participant direction of services and any processes established for quality assurance and quality improvement of services.

In addition to meeting any provider requirements specified under 42 CFR Part 440.180 for home and community-based waiver services, providers of other State plan services furnished to youth under this demonstration project must also meet any provider qualifications specified for the services at 42 CFR 440 subpart A. For example, 42 CFR 440.110 contains specific provider requirements for physical therapists, occupational therapists, speech pathologists, and audiologists.

In the Implementation Plan of this demonstration, the State:

- Must specify the provider qualifications and establish a procedure for verification of provider qualifications.

- Should specify whether a criminal history or background investigation is conducted for providers and whether an abuse registry is maintained.

- Must specify the process(es) that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as specified at 42 CFR 431.51.

- Should indicate whether legally responsible individuals may be paid for the provision of personal care or similar services and what qualifications must be met.

- Should indicate whether other policies concerning payment for waiver services furnished by relatives/legal guardians have been established and specify the circumstances under which payment can be made.

- Should indicate the method of service delivery, (i.e., whether it is participant-directed or provider managed).

G. Implementation Plan Requirements

If awarded, States will be required to complete an Implementation Plan (IP). This plan will resemble, in content and context, the new HCBS waiver application with modifications. At a minimum, IPs must address the components listed below in the design, operation, and administration of the demonstration project. To learn more about the new HCBS waiver application, visit http://www.cms.hhs.gov/HCBS/02_QualityToolkit.asp#TopOfPage and click on HCBS Waiver Application [Version 3.3][ZIP 2.0MB]link.

1. **Demonstration Administration and Operation.** States will be required to specify the administrative and operation structure of the demonstration.

2. **Participant Access and Eligibility**. Specify the target group(s) of individuals who are served under the demonstration, the number of participants that the State expects to serve during each year that the demonstration is in effect, applicable Medicaid eligibility requirements, and procedures for the evaluation and re-evaluation of level of care.

3. **Participant Services**. Specify the services that are furnished through the demonstration, including applicable limitations on such services.

4. **Participant Direction of Services.** When the State provides for participant direction of services, specify the supports provided in the demonstration to support participant direction of demonstration services.

5. **Participant Rights.** Specify how the State informs participants of the Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

6. **Participant Safeguards.** Describe the safeguards that the State has established or will establish to ensure the health and welfare of participants.

7. **Quality Management Strategy.** Describe the process, procedures, and strategies employed by the State to discover, remedy, and improve the overall operation and administration of the demonstration project. The description should provide information detailing the frequency of which information, tracked, trended, and reported out on, as well as those individuals and groups that receive such information.

8. **Financial Neutrality Demonstration.** The IP will adhere to the funding requirements found in Section H, below.

H. Funding Requirements

Budget Neutrality: In conducting these demonstration projects, The Secretary of Health and Human Services shall ensure that the aggregate payments made by the Secretary under title XIX of the Act (42 U.S.C. 1396 et seq.) do not exceed the amount which the Secretary estimates would have been paid under the title, if the demonstration projects under section 6063 had not been implemented.

As a part of the IP, States will be required to submit a Financial Neutrality Demonstration Form (Attachment 5). For the purposes of this demonstration, the maximum payment made to each State will be determined using the following formula:

The Aggregate HCBS Service Costs
Aggregate PRTF Costs of unduplicated service recipient enrollees.

1. A State receiving an award under this solicitation will receive reimbursement for home and community-based services provided under the demonstration on a quarterly basis at a rate equal to the State's Federal Medical Assistance Percentage (FMAP). Administrative costs will be reimbursed according to the requirements of 42 CFR §433.15.

- This funding will only be released for access by States, if States have an approved IP. If States submit an IP for review, and it is approved prior to the required submission deadline, that State may access Federal fund reimbursement described above any time after approval, according to the conditions set forth in the IP and HCBS budget.

- Any funding allocated for the Federal match for provided under the demonstration for the first year of this grant that remain unspent will be carried over to the next year of the Grant.

2. Funding for years 2008 – 2011 will be awarded by a Continuation Grant to each State, based on their approved Financial Neutrality Formula and updated IP. Any funding allocated for the Federal match for HCBS provided under the demonstration that remains unspent will be carried over to the next year of the Grant.

3. For additional information please see the draft report "Financing Home and Community Services for Youth with Serious Emotional Disorders and Their Families: Current State Strategies." This research from the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and Mathematica Policy Research, Inc. can be found using the link: http://aspe.hhs.gov/daltcp/reports/2006/youthSED.pdf

I. Financial Reporting

- Financial Status Report, form (SF-269), will be required to be submitted semi-annually. This financial status report will account for all uses of grant monies during each reporting period. During the pre-implementation period, CMS will work with the grantees to determine if additional reporting requirements imposed.

- At the end of each demonstration grant year, States will be required to produce documentation that they have not exceeded the determined budget ceiling and have met all CMS financial requirements. The format of this financial report will be determined during the IP phase of the Demonstration

J. Semi-Annual Progress Reports

Web-based reports in a pre-determined format will be required to be submitted semi-annually. The submission of the finalized IP will be **due no later than 9 months** after receipt of the Notice of Financial Assistance Award. The IP will be considered the First report due under this demonstration.

K. Evaluation

Evaluation data collection:

- CMS will issue a request for proposals to acquire the services of a national evaluation contractor. The evaluation will explore two primary questions posed in the statute: Does the provision of home and community-based services to youth under this demonstration result in (1) the maintenance or improvement in a child's functional status; or (2) on average, cost no more than anticipated aggregate PRTF expenditures in the absence of the Demonstration?

- States may use any of several validated functional assessment tools to measure the functional status of youth in the Demonstration (see Attachment 3 for a Web link to validated tools). Individual level data on demographic, functional, and cost variables must be made available to CMS to be evaluated by a CMS contractor to be determined at a later date. Awardees must agree to work with the CMS evaluation contractor to determine a minimum data set that all grantees will provide to CMS to answer the above questions. States agree to report minimum data set variables to CMS on a quarterly basis.

II. AWARD INFORMATION

1. Award Table

Grant Opportunity	Total Funding	Who May Apply?	Max. No. of Grant Awards per State	Maximum Award	Maximum Project Period	Percent Allowable for Direct Services*	Estimated Number of Awards
CFDA # 93-789	$217,000,000	States	1	$21,700,000-$50,000,000 (Up to $2.1 million for year one)	5 years	n/a	10

2. **Amount of Funding**
Section 6063 of the DRA appropriated $218 million for this demonstration period, and, of that amount, $1 million is made available for the required interim and final national evaluations and reports.
Fiscal Year Amounts for the Demonstration:

Fiscal Year 2007	$21,000,000
Fiscal Year 2008	$37,000,000
Fiscal Year 2009	$49,000,000
Fiscal Year 2010	$53,000,000
Fiscal Year 2011	$57,000,000

The amount available for each project year, beginning in fiscal year 2008, shall be the amount appropriated for that project year, plus any remaining unexpended funds from prior project years. Each project year, awardees will be required to submit a request for a grant continuation award that will be funded from the new fiscal year appropriation. Awards will be made based on the review and approval of an updated Financial Neutrality Form submission and a review of each State's approved IP.

3. **Period of Performance**
The period of performance for this project is for 5 years from the date of the initial Financial Assistance Award.

III. Other

1. **Eligible Applicants**
Any single State Medicaid Agency, State Mental Heath Agency, or instrumentality of the State may apply for this Demonstration Grant. Only one application can be submitted for a given State.

Each application for this Demonstration Grant must include a letter of endorsement from the Director of the Mental Health Authority and the State Medicaid Director, if the applicant is not the single State Medicaid Agency/State Agency.

Applicants are strongly encouraged to include in an indexed appendix, additional letters of support and/or current memorandums of understanding from major partners, including consumers. These letters and memorandums give substantive support to the applicant's project narrative and describe the extent of partnering in the community and the involvement of consumers. Applicants should include all such letters as part of their application package. CMS cannot guarantee that any letters submitted separately will be matched with the correct application.

States
By "State" we refer to the definition provided by Federal regulations at 45 CFR 74.2 as "any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any

agency or instrumentality of a State exclusive of local governments." By "territory or possession" we mean Guam, the U. S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

2. Cost Sharing or Matching

The CMS will reimburse States for HCBS provided under the demonstration on a quarterly basis at a rate equal to the State's FMAP. (See Attachment 6, for a list of HCBS categories). Administrative costs will be reimbursed according to the requirements at 42 CFR 433.15.

3. Eligibility Threshold Criteria

Applications not received by the application deadline will not be reviewed.
Even though an application may be reviewed and scored, a grant will not be funded if the application fails to meet any of the requirements as outlined in, Section III, *Eligibility Information* and, Section IV, *Application Review Information*. Any application that fails to meet Financial (Budget) Neutrality will not meet eligibility criteria.

Applicants are **strongly encouraged** to use the review criteria information provided in Section V, *Application Review Information*, to help ensure that you adequately address all the criteria that will be used in evaluating the proposals.

IV. APPLICATION AND SUBMISSION INFORMATION

Applicants must submit their applications electronically through http://www.grants.gov. Please note when submitting your application electronically, you are required, additionally, to *mail* a signed SF-424 to Ms. Nicole Nicholson, Centers for Medicare & Medicaid Services, Office of Operations Management, Acquisition and Grants Group, Mailstop C2-21-15, 7500 Security Boulevard, Baltimore, MD 21244-1850. The mailed SF-424 form may be received at the Centers for Medicare & Medicaid Services within 2 business days of the application closing date.

1. Address to Request Application Package

- A complete electronic application package, including all required forms, for this demonstration grant is available at https://apply.grants.gov/forms_apps_idx.html

Standard application forms and related instructions are available online at http://gsa.gov/forms.

Standard application forms and related instructions are also available from Ms. Nicole Nicholson, Centers for Medicare & Medicaid Services, Office of Operations Management, Acquisition and Grants Group, Mailstop C2-21-15, 7500 Security Boulevard, Baltimore, MD 21244-1850, (410) 786-5158, or by e-mail at Nicole.Nicholson@cms.hhs.gov.

2. Content and Form of Application Submission

Form of the Application (Applicants must submit their applications electronically)

- The only acceptable formatting is 8.5" x 11" letter-size pages with 1" margins (top, bottom, and sides).
- All pages of the project narrative must be paginated in a single sequence. The proposed budget must directly follow the narrative and be paged within the same page sequencing.
- Font size must be no smaller than 12-point with an average character density no greater than 14 characters per inch.
- The narrative portions of the application must be SINGLE SPACED.
- The Project Abstract should be no more than one page long.
- The titles and sequence of the headings in the project narrative must coincide with the wording and sequencing used in the solicitation.
- The Project Narrative (not including the required SF-424 & 424A) of the application is limited a 24 page, single-spaced, single-sided limit. The budget form to be submitted is the required Attachment #5

Required Contents of the Application

A. Notice of Intent to Apply

Applicants are encouraged to submit a non-binding Notice of Intent to Apply. Notices of Intent to Apply are not required and their submission or failure to submit a notice has no bearing on the scoring of proposals received. But receipt of such notices enables CMS to better plan for the application review process. These may be submitted in any format; however, a sample is included in Attachment 1. *Notices of Intent to Apply are due **September 8, 2006,** and should be faxed to Ms. Sona Stepp at 410-786-9004.*

B. Standard Forms (SF)

Standard forms are available as detailed in, Section V.A, *Address to Request Application Package.* The following standard forms must be completed with an original signature and enclosed as part of the proposal:

SF-424: Official Application for Federal Assistance (see **Note** below*)
SF-424A: Budget Information
SF-424B: Assurances—Non-Construction Programs
SF-LLL: Disclosure of Lobbying Activities
PHS-5161-1 (7/00) Additional Certifications – can be found at the following Web site:
http://apply.grants.gov/forms/sample/SSA_additionalassurances_VI.0.pdf

Note: On SF-424 "Application for Federal Assistance":

*Check "No" to item 16b, as Review by State Executive Order 12372 does not apply to these grants.

C. Required Letters of Endorsement

If the applicant is not the single State Medicaid Agency, a letter of support from the State Medicaid Director must be included. Additional letters of endorsement from the major

partners that are not the lead agency are encouraged, such as the Department of Social Services, Department of Education and Juvenile Justice.

Failure to include the required letter of support from the Medicaid Director will result in an incomplete application, which is not eligible for review or award.
If the applicant is a single State Medicaid Agency, the agency must declare they are a single Medicaid Agency in their cover letter.

D. Project Abstract
The one-page abstract (not included in the Narrative/Budget page count) should serve as a succinct description of the proposed project and should include the goals of the project, the total budget, a description of how the grant will be used to develop or improve community-integrated services, and the ultimate outcomes and products.

E. Applicant's Application Cover Letter
A letter from the State Mental Health Authority Director identifying the agency serving as the lead organization, indicating the title of the project, the principal contact person, amount of funding requested, and the names of the major partners actively collaborating in the project. **If the applicant is a single State Medicaid Agency, the agency must declare they are a single Medicaid Agency in their cover letter.**

The letter should indicate that the submitting agency has clear authority to oversee and coordinate the proposed activities and is capable of convening a suitable working group of all relevant partners. This letter should be addressed to:

Ms. Judith Norris
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Mailstop C2-21-15
7500 Security Boulevard
Baltimore, MD 21244-1850

F. The Structure and Content of the Application Narrative

The project narrative should provide a concise and complete description of the proposed demonstration project. The content of the project narrative for this Demonstration Grant is composed of five parts, as discussed in Section IV.1, and has a **24 page, single-space, single-sided limit, plus the completion of the Budget Neutrality Form.**

- **Part 1: Systems Assessment** (Maximum 6 single-spaced pages)

    1. Provide a description of the criteria for admission to PRTF.
    2. How many PRTFs that meet the demonstration's definition are operated in your State? How many, total, PRTF beds do you license and are certified to receive the Medicaid under 21 benefit? What is the occupancy rate of those beds and average length of stay of the youth in those beds? The number of youth receiving

PRTF services in out-of-State placements? Describe the characteristics of the youth currently served in PRTFs, including diagnoses, age, gender, and, ethnicity.

3. If the States contracts with PRTF providers that reside out of State, provide a description of the contractual obligations of the PRTF and any limitations on purchase of beds.
4. Provide a description of the various systems of care that are utilized by the State to provide services to youth. These systems include but are not limited to, juvenile justice, foster care, and education. Describe the services currently provided in these systems.
5. Explain how these systems are currently integrated financially, functionally, and organizationally, and comport to best support youth in the community.
6. Describe how functional outcomes are currently measured for youth served in PRTFs, and other systems providing care to the target population.
7. Provide the criteria for determining who is eligible under each of these systems.
8. Provided a description of progress being made by the applicant to further integrate these systems of care and explain the barriers in creating an integrated system of care.
9. Provide a description of funding issues that affect the ability to deliver a comprehensive and coordinated system of care.
10. Describe any gaps in the ability to provide a comprehensive set of services and supports to youth in the community.
11. Describe any gaps in the ability to provide services in settings of a home and community character.
12. Provide an assessment of the cultural and linguistic competency possessed by the home and community-based system of care. Describe any gaps in the ability of the State to provide all services and supports in a culturally and linguistically appropriate manner.

- **Part 2: Development Plan** (**Maximum 12 single-spaced pages**)

Submit a Development Plan for the proposed program of integrated supports and services necessary to address the issues identified in the systems assessment containing the elements listed below:

1. Goal: State the overall goal of the program.
2. Problem Statement: Define the problem(s) that prevent the target population(s) from receiving comprehensive, integrated HCBS. Include a description of the variables found in section 2.A, page 7, of this application.
3. Demonstration Design and Development: Describe how you will meet the statutory and regulatory requirements governing the administration and operation of a section 1915(c) waiver addressing comparability, State-wideness, and income and resources for the medically needy.
4. Participant Recruitment: Describe the intended target population and how they will be identified, recruited, and retained. Provide the eligibility criteria for admission to the project. Provide, in an indexed appendix, a copy of your State's Level of Care Assessment. To the degree that third parties are involved in

recruitment, their roles must be specified and letters of commitment attached and in an indexed appendix.

5. Interventions: Describe the intended service delivery approach(es) and services and supports that will be offered to participants in the demonstration. Provide the rationale (including research results) for any services not listed under the HCBS listed in Attachment 6. Discuss how these services will be culturally appropriate to the enrollees.
6. Systems Quality: Describe how the Applicant will approach quality of care throughout the life of the project. Describe how you will ensure service model fidelity through implementation and operations, of the program. How will service utilization data be used to determine benchmarks for functional outcomes and quality improvement activities?
7. Provider Requirements: Describe how the Applicant will ensure that service providers meet requirements. Include any training that will be necessary and how training will be delivered.
8. Implementation Plan: Indicate how the Applicant will approach the IP development process. Include a proposed outline of the implementation phase of the grant program. The outline must include a preliminary description of the proposed goals and objectives you will address during the implementation phase.
9. Information Systems: Describe any information systems changes needed in order to implement the program.
10. Technical Assistance Plan: Identify any areas/activities, for which technical assistance is required, the process for acquiring technical assistance (e.g., contract), the technical assistance entity, and a detailed budget for procurement of technical assistance.
11. Stakeholder Involvement: Describe how you will involve stakeholders in the Development Phase, and Implementation Phase of this demonstration, and how these stakeholders will be involved throughout the life of the grant.
12. Statement of Assurance: Provide a statement in an indexed appendix that the State will assure the necessary safeguards to protect the health and welfare of youth receiving home and community-based care under this demonstration.

- **Part 3: Organizational and Staffing Plan** (**Maximum 3 single-spaced pages**)

1. Organizational structure (maximum 1 page)
   Provide an organizational chart that describes the entity that is responsible for the management of this grant and how that entity relates to all other departments, agencies, and service systems that will provide care and services and have interface with the youth enrolled under this grant.
2. Staffing Plan (maximum 2 pages)
   Provide a staffing plan that includes:
   - The number and title of dedicated positions to the grant. Please indicate which is key staff assigned to the grant.
     - percentage of time each individual/position is dedicated to the grant
     - brief description of role/responsibilities of each position
   - Number of contracted individuals supporting the grant
     - percentage of time each individual will provide to the grant

- brief description of role/responsibilities of each position

- **Part 4: Evaluation Plan** (**Maximum of 3 pages)**

  Please address the following considerations in the evaluation section:

  A. **Evaluation Design:** Briefly describe the evaluation design proposed for the demonstration. CMS will support non-experimental and quasi-experimental design models that address the demonstration research questions. Provide evidence that the pool of potential demonstration participants within the proposed project area is adequate to provide for a project that will reach valid conclusions. Discuss any hypotheses to be tested in addition to those provided in the statute and relate those hypotheses' policy implications relevant to the demonstration goals. Discuss how the fidelity of proposed interventions will be maintained.

  B. **Variables:** Please describe the demographic, health care, and functional outcome variables you propose to collect in the demonstration. Provide a copy in an indexed appendix to the application. Describe the instruments and provide a rational for their use in the evaluation including reliability, validity, and appropriateness for use on the study population. Applicants must measure functional outcomes on participants across the categories listed below.

  - Community living: Days in PRTF, days in out-of-home placement, days in home of choice, days in psychiatric hospital, days in other out-of-home placement. Include these community living variables for disproportionate out-of-home placement for minority youth
  - School Functioning: Absences from school, changes in grade point average, number of disciplinary actions at school.
  - Juvenile Justice Outcomes: Number of contacts with law enforcement personnel, number of arrests, number of convictions.
  - Family Functioning: Number of abuse and neglect reports, family support for child's needs.
  - Alcohol and other Drug use: Decrease in alcohol and other drug use. Decrease in exposure to alcohol and other drugs.
  - Mental health: Reduction in symptoms, increase in cognitive functioning. Positive goal directed behavior including increased purpose in life, sense of self-efficacy, internal locus of control, reduction in suicidal behavior.
  - Social support: Increase in frequency and amount of positive friendships.
  - Program satisfaction: Family and child satisfaction. Wraparound child and family team satisfaction.
  - Environmental variables: Family is able to maintain stable housing, income, and transportation adequate to meet their needs.

  C. **Minimum data set to CMS:** CMS may want access to individually identifiable functional assessment data for purposes of project-to-project comparisons. Please propose a minimum data set that would be included in the quarterly report to CMS. Acceptance of the proposal does not necessarily imply that the proposed minimum data set will be accepted without

modification. The final minimum data set will be determined by CMS, the CMS evaluation contractor and the State participants in the project. The applicant and evaluator must demonstrate that they can collect, maintain, and access person-specific data in order to evaluate the project.

- **Part 5: Budget Presentation and Narrative (Completion of the Form)**
  The budget presentation required is completion of Attachment 5 of this solicitation, titled Financial Neutrality Form. Instructions for completion of this form follow the Financial Neutrality Form in Attachment 5.

  Any funding allocated for the Federal match for HCBS provided under the demonstration for the first year of this grant that remain unspent will be carried over to the next year of the Grant.

  *In addition, completion of the Budget Form 424A for year one of the project remains a requirement for consideration of your application (See Section IV, B).

G. Appendices- Applicants (*A Table of Contents is Required)

- All documents required for the System Assessment identified by the 12 system assessment issues. Please note in your narrative the appendix/attachment number, document reference number, and page number for each identified document.
- Letters of support.
- Other support documentation referenced by the section and number of the solicitation and identified by the appendix/attachment number, document reference number, and page number.

H. Attachments

Attachment 1: Notice of Intent to Apply (Faxed to CMS as instructed in C-1 of this section)
Attachment 2: Prohibited Use of Grant Funds
Attachment 3: Functional Assessment
Attachment 4: Systems of Care
Attachment 5: Financial Neutrality Demonstration Budget Form and Instructions
Attachment 6: Home and Community-Based Services Core Services Definitions

3. Submission Dates and Times

A. Notices of Intent to Apply

Encouraged, Notices of Intent to Apply for a grant are due by September 8, 2006, and should be faxed to Ms. Sona Stepp at 410 786-9004. It is not mandatory for an applicant to submit a Notice of Intent to Apply; however, such submissions help CMS plan its review process, including its review panels. Submission of a Notice of Intent to Apply does not bind the applicant to apply; nor will it cause a proposal to be reviewed more favorably.

B. Grant Applications (DUE DATE)

All grant applications are due by October 18**,** 2006**.** Applications submitted through http://www.grants.gov until 11:59 p.m. Eastern time on October 18, 2006, will be considered "on time." All applications will receive an automatic time stamp upon submission, and applicants will receive an automatic e-mail reply acknowledging the application's receipt.

Please note when submitting your application electronically you are required, to *mail* a signed SF-424 to Ms. Nicole Nicholson, Centers for Medicare & Medicaid Services, Office of Operations Management, Acquisition and Grants Group, Mailstop C2-21-15 Central Building, 7500 Security Boulevard, Baltimore, MD 21244-1850. The mailed SF 424 form may be received at the Centers for Medicare & Medicaid Services within 2 business days of the application closing date.

C. Late applications will not be reviewed.

Grant Awards: Time frame

All grant awards will be made on or about November 24, 2006 for a start date of December 1, 2006. The Demonstration Grants awarded under this funding opportunity will have a budget period of 60 months.

4. Intergovernmental Review

Applications for these grants are not subject to review by States under Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100).

5. Funding Restrictions

Indirect Costs

The provisions of the Office of Management and Budget (OMB) Circular A-87 govern reimbursement of indirect costs under this solicitation. A copy of OMB Circular A-87 is available online at: http://www.whitehouse.gov/omb/circulars/a087/a087.html

Direct Services

The object of this grant is to provide Federal Fund reimbursement for direct services.

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Reimbursement of Pre-Award Costs

No grant funds awarded under this solicitation may be used to reimburse pre-award costs.

6. Other Submission Requirements

Electronic Applications

The deadline for all applications to be submitted through http://www.grants.gov is **October 18, 2006**. For information on how to get started with Grants.gov, please visit http://www.grants.gov/applicants/get_registered.jsp. **We strongly recommend** that you **do not** wait until the application deadline date to begin the application process through

Grants.gov. We recommend you **visit Grants.gov at least 30 days prior to filing your application** in order to fully understand the process and requirements. We encourage applicants to submit well before the closing date.

Also visit the following Web site: http://www.grants.gov/resources/newsletter.jsp for all of the latest information about the benefits and success of this initiative. In order to submit their applications electronically, applicants will need to:

- Download and install PureEdge Viewer from the grants.gov website. (http://www.grants.gov/DownloadViewer). This small, free program will allow applicants to access, complete, and submit applications electronically and securely.
- Find an opportunity for which you wish to apply at: http://www.grants.gov/applicants/find_grant_opportunities.jsp and record the Funding Opportunity number or CFDA. You will need to enter the Funding Opportunity and/or CFDA number to access the application package and instructions.
- Download the complete electronic grant application package from at: https://apply.grants.gov/forms_apps_idx.html
- The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the following Web site: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in the block with the applicant's name and address on the cover page of the application (Item 5 on the Form SF-424, Application for Federal Assistance), with the annotation "DUNS" followed by the DUNS number that identifies the applicant. The name and address in the application should be exactly as given for the DUNS number.

Register with the Credential Provider—Applicants must register with the Credential Provider to receive a username and password to securely submit their grant application.

Register with http://www.grants.gov—Registering with grants.gov is required to submit grant applications electronically on behalf of your organization. After completing the registration process, applicants will receive e-mail notification confirming their ability to submit applications through Grants.gov. (Technical support for Grants.Gov is available Monday-Friday from 7:00 a.m. to 9:00 p.m. Eastern time.)

Upon submission of the grant application to http://www.grants.gov, applicants will receive an e-mail confirming that the application was received.

Applicants may not submit the same application in more than one format, and the choice of one application format over another will not cause an application to be reviewed more favorably. All standard application forms may be obtained as detailed in Section V.A, *Address to Request Application Package,* of this solicitation.

For assistance with the grants.gov online process, including registration, installing the PureEdge viewer, up-loading documents, and password problems, please contact grants.gov directly at 1-800-518-4726. Please do not contact CMS regarding grants.gov related issues.

V. Criteria

Applicants are strongly encouraged to examine the review criteria provided in this section.

1. Review Criteria

This section fully describes the evaluation criteria for the funding opportunity for which this solicitation applies.

In preparing applications, applicants are strongly encouraged to review the programmatic requirements detailed in, Section I, Funding Opportunity Description. The Project Narrative **must** be organized as detailed in, Section IV, Application and Submission, of this solicitation. Any application that fails to meet Financial (Budget) Neutrality will not meet eligibility criteria and will not be scored.

Scoring

The review process for this grant category has five (5) sections. The maximum possible score is **100 points**.

Systems Assessment	30 points
Development Plan	40 points
Organizational and Staffing Plan	10 points
Evaluation Plan	10 points
Financial Neutrality	10 points

Part A: Review Criteria: Systems Assessment
(Total maximum possible score = 30 points)

- Did the Applicant provide a complete description of the criteria used by the Applicant for admission to PRTF, to enable the reviewer to have a practical understanding of the process?
- Did the Applicant presented the following information on the PRTFs that meet the demonstration's definition.
    - Total number of PRTFs.
    - Total number of PRTF beds that are licensed and are certified to receive the Medicaid under 21 benefit.
    - What is the occupancy rate of those beds?
    - What is the average length of stay of the youth in those beds?
    - The number of youth receiving PRTF services in out-of-Applicant placements.
- If the Applicant contracts with PRTF providers that reside out of Applicant, did the Applicant provide a detailed description of the contractual obligations with the out-of- Applicant PRTF and any limitations on the purchase of beds?

- Did the Applicant describe the characteristics of the youth currently served in PRTFs, including diagnoses, age, gender, and ethnicity?
- Did the Applicant provide a detailed description of the various systems of care that are utilized by the Applicant to provide mental health services to youth? (These systems include, but are not limited to, juvenile justice, foster care, and education.) Did the Applicant describe the services currently provided in these systems?
- Has the Applicant provided a detailed explanation of how these systems are currently integrated both functionally and organizationally, and comport to best support youth in the community?
- Did the applicant describe how functional outcomes are currently measured for youth served in PRTFs, and other systems providing care to the target population?
- Has the Applicant provided detailed criteria for determining who is eligible for services under each of these identified systems of care?
- Has the Applicant provided a description of progress being made by the applicant to further integrate these systems of care and explained the barriers in creating an integrated system of care?
- Did the Applicant provide a description of funding issues that affect the ability to deliver a comprehensive and coordinated system of care?
- Did the Applicant adequately describe any gaps in the ability to provide a comprehensive set of services and supports to youth in the community?
- Is there evidence that the Applicant addressed any gaps in their ability to provide these services in home and community-based settings? Did the Applicant describe any disproportionate placement of minority youth in PRTFs?
- Has the Applicant provided an assessment of their cultural and linguistic competency assets and/or deficits of their home and community-based system of care?

Part B: Review Criteria: Development Plan
(Total maximum possible score = 40 points)

- Does the application include a clear and achievable goal statement?
- Does the application include a well-defined problem statement?
- Did the Applicant adequately describe how they plan to meet the statutory and regulatory requirements of the 1915(c) waiver application?
- Does the application adequately describe the participant recruitment plan? Does it include appropriate eligibility criteria?
- Did the Applicant provide the Applicant's Level of Care Assessment in an indexed appendix?
- Does the proposal adequately describe the intervention models and services the Applicant plans on delivering?
- Did the Applicant adequately describe how quality management will be conducted? Did the applicant include a plan to ensure the fidelity of evidence based models of care they are proposing? Is there a plan to use service utilization data to manage quality throughout the life of the grant?

- Did the Applicant adequately describe how it will ensure that providers meet the requirements necessary to perform the service functions?
- Does the proposal provide a viable approach to develop the IP?
- Did the Applicant describe any information systems enhancements needed in order to implement the program?
- Does the application adequately address technical assistance needed to develop the plan?
- Did the Applicant adequately describe how it will include stakeholders, including youth consumers and their families, in the Development and Implementation phases of the grant process?

Part C: Review Criteria: Organizational and Staffing Plan
(Total maximum possible score = 10 points)

- Did the Applicant provide an organizational chart that describes the entity that is responsible for the management of this grant and how that entity relates to all other departments, agencies, and service systems that will provide care and services and have interface with the youth that will be enrolled under this grant? Is this graphic representation easy to understand and follow how the organizational units relate to one another and to the community?
- Did the Applicant provide a staffing plan that identifies dedicated key positions?
- Is the percentage of time each individual/position is dedicated to the grant adequate to provide the leadership and task completion required by the grant?
- Did the Applicant provide brief descriptions of role/responsibilities of each position?
- Did the Applicant provide brief descriptions of the role each key person would have in the management of the grant?
- If the Applicant identified key contractual and/or in-kind positions, were the brief descriptions of the role each key person providing management of the grant provided?

Part D: Review Criteria: Evaluation Plan
(Total maximum possible score = 10 points)

- Does the proposed evaluation design:
  - Address evaluating the functional level of the enrollees both in the PRTF and in the community, as well as the evaluation of cost effectiveness?
  - Include any hypotheses to be tested and their relevance to the demonstration?
  - If proposed, describe non-experimental or quasi-experimental design?
  - Describe how the fidelity of the proposed interventions will be maintained?
- Does the proposal contain an adequate description of the survey instruments and variables the Applicant wishes to collect in their evaluation? Did the Applicant describe how it will address the required variables listed on page 26 of the solicitation?

Part E: Review Criteria: Financial Neutrality Form
(Total maximum possible score = 10 points)

- In reviewing the Financial Neutrality Form, did the applicant:

- Complete the form for all 5 years of the demonstration?
- Follow the Financial Neutrality Form instructions?
- Provide a list of demonstration services that are indicated in the demonstration design and the service costs are appropriately budgeted.

2. Review and Selection Process

How the Merit of Applications Will Be Determined:

The CMS will employ a multiphase review process to determine the applications that will be reviewed and the merit of the applications that are reviewed. The multiphase review process includes the following:

- Applications will be screened by Federal staff to determine eligibility for further review using the criteria detailed in the "Eligibility Information" section of this solicitation. Applications that are received late or fail to meet the eligibility requirements as detailed in the "Applicant Eligibility" section of this solicitation will not be reviewed.
- Applications will be objectively reviewed by a panel of experts, the exact number and composition of which will be determined by CMS at its discretion, but may include private sector subject matter experts, beneficiaries of Medicaid supports, and Federal and Applicant policy staff. The review panels will utilize the objective criteria described in the "Application Review Criteria Information" section of this solicitation to establish an overall numeric score for each application.
- The results of the objective review of applications will be used to advise the approving CMS official. Additionally, CMS staff will make final recommendations to the approving official after ranking applications, using the scores and comments from the review panel and weighing other factors as described below.

Factors Other than Merit that May be Used in Selecting Applications for Award:

The CMS may assure reasonable balance among the grants to be awarded in terms of key factors such as geographic distribution and broad target group representation. CMS may redistribute grant funds (as detailed in the "Award Information" section of this solicitation) based upon the number and quality of applications received. (e.g., to adjust the minimum or maximum awards permitted or adjust the aggregate amount of Federal funds allotted to a particular category of grants).

3. Anticipated Announcement and Award Date

Awards will be announced and awarded on or about November 24, 2006.

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Successful applicants will receive a Financial Assistance Award (FAA) signed and dated by the CMS Grants Management Officer. The FAA is the document authorizing the grant award and will be sent through the U.S. Postal Service to the applicant organization at the address listed on its SF-424. Any communication between CMS and applicants prior to issuance of the FAA is not an authorization to begin performance of a project.

Unsuccessful applicants will be notified by letter, sent through the U.S. Postal Service to the applicant organization at the address listed on its SF-424, after December 1, 2006.

2. Administrative and National Policy Requirements

Usual Requirements

A. Specific administrative and policy requirements of grantees as outlined at 45 CFR Part 74 and 45 CFR Part 92, apply to this grant opportunity.
B. All grantees receiving awards under these grant programs must meet the requirements of:
    a. Title VI of the Civil Rights Act of 1964,
    b. Section 504 of the Rehabilitation Act of 1973,
    c. The Age Discrimination Act of 1975,
    d. Hill-Burton Community Service nondiscrimination provisions, and
    e. Title II, Subtitle A, of the Americans with Disabilities Act of 1990.
C. All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the grantee's original grant application or agreed upon subsequently with CMS, and may not be used for any prohibited uses.
D. Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project.
E. State grantees must coordinate their project activities with other State, local, and Federal agencies that serve the population targeted by their application (e.g., Administration for Youth and Families, Administration for Developmental Disabilities, Department of Education, etc.). CMS also encourages collaboration with a broad range of public and private organizations whose primary purpose is advocating for youth, volunteer groups, faith-based service providers, private philanthropic organizations, and other community-based organizations.

Terms and Conditions

A funding opportunity award with CMS will include standard terms and conditions and may also include additional specific grant "special" terms and conditions. Potential applicants should be aware that special requirements could apply to grant awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the review panel or CMS.

3. Reporting

Grantees must agree to cooperate with any Federal evaluation of the program and provide semi-annual (every 6 months) and final (at the end of the grant period) reports in a form prescribed by CMS (including the SF-269a "Financial Status Report" forms). Reports will be submitted electronically. These reports will outline how grant funds were used, describe program progress, and describe any barriers and measurable outcomes. CMS will provide a format for reporting and technical assistance necessary to complete required report forms. Grantees must also agree to respond to requests that are necessary for the evaluation of the national efforts and provide data on key elements of their own grant activities.

VII. AGENCY CONTACTS

1. Programmatic Content Questions

Programmatic questions about this demonstration grant may be directed to an e-mail address that multiple people access, so that someone will respond even if others are unexpectedly absent during critical periods. Please use this e-mail address: **PRTF-DEMO@cms.hhs.gov.**

Personal contact for this Demonstration**:**

Mr. Ron Hendler
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
DEHPG/DASI, Mailttop S2-14-26
7500 Security Boulevard
Baltimore, MD 21244-1850
410-786-2267 (voice) or 410-786-9004 (fax)
Or:
Ms. Sona Stepp
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
DEHPG/DASI, Mailstop S2-14-26
7500 Security Boulevard
Baltimore, MD 21244-1850
410-786-6815 (voice) or 410-786-9004 (fax).

2. Administrative Questions

Administrative questions about This Demonstration Grant should be directed to:

Ms. Nicole Nicholson
Centers for Medicare & Medicaid Services
Office of Operations Management
Acquisition and Grants Group
Mailstop C2-21-15

7500 Security Boulevard
Baltimore, MD 21244-1850
(410) 786-5158 (voice), 410-786-9088 (fax)
or by e-mail at Nicole.Nicholson@cms.hhs.gov.

VIII. Other Information

Attachment 1 – Notice of Intent to Apply
Attachment 2 – Prohibited Uses of Grant Funds
Attachment 3 – Functional Assessments
Attachment 4 – Systems of Care
Attachment 5 – Financial Neutrality Form & Instructions
Attachment 6 – Home and Community-Based Core Services

ATTACHMENT 1

Notice of Intent to Apply

Submission by Facsimile--- Send To: Fax: 410-786-9004

Please complete and return**,** by **September 8, 2006**, to:

Sona Stepp
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Phone: 410-786-6815, Fax: 410-786-9004

1. **Name of State: _____**

2. **Applicant Agency/Organization: _____**

3. **Contact Name and Title**:_____

4. **Address:**_____

5. **Phone: _____ Fax: _____**

6. **E-mail address: _____**

ATTACHMENT 2

Prohibited Uses of Grant Funds

Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant for FY 2006 funds may not be used for any of the following:

1. To provide direct services to individuals, except as explicitly permitted under each grant solicitation. Direct services do not include expenses budgeted for consumer task force member participation in Real Choice Systems Change for Community Living Conferences or for project staff to attend Technical Assistance Conferences sponsored by CMS or its national technical assistance provider.
2. To match any other Federal funds.
3. To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
4. To provide infrastructure for which Federal Medicaid matching funds are available at the 90/10 matching rate, such as certain information systems projects.
5. To supplant existing State, local, or private funding of infrastructure or services such as staff salaries, etc.
6. To be used for expenses that will not primarily benefit individuals of any age who have a disability or long-term illness.
7. To be used for ongoing administrative expenses related to Medicaid services unless such administration is part of a well-defined test of alternate and improved methods focused specifically on personal assistance services that maximize consumer control.
8. To be used for data processing software or hardware in excess of the personal computers required for staff devoted to the grant.

ATTACHMENT 3

Functional Assessment Instruments for Youth with Serious Emotional Disturbances

SEE:

Rutgers Center for State Health Policy: Assessment of Children: Issues and Instruments
http://www.hcbs.org/files/66/3259/SEDBriefIIAssessmentofChildren.pdf

ATTACHMENT 4

Systems of Care

Rutgers Center for States Health Policy: A Series of Issues Briefs on Strengthening Systems of Care for Children and Adolescents with Severe Emotional Disturbance.
http://www.hcbs.org/moreInfo.php/nb/doc/1169/A_Series_of_Issues_Briefs_on_Strengthening_Systems

Substance Abuse and Mental Health Services Administration Systems of Care
http://www.mentalhealth.samhsa.gov/publications/allpubs/KEN95-0016/default.asp

National Technical Assistance Center for Children's Mental Health
Georgetown University
http://gucchd.georgetown.edu/programs/ta_center/tacenterapproach.html

ATTACHMENT 5

Financial Neutrality Demonstration Budget

C-1: Composite Overview and Demonstration of Neutrality Formula

Composite Overview: Complete the following table for each year of the demonstration.

Level of Care: Psychiatric Residential Treatment Facilities							
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1							
2							
3							
4							
5							

C-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants who will be served each year that the demonstration is in operation.

Table C-2-a: Unduplicated Participants

Demonstration Year	Total Unduplicated Number of Participants (From Item B-3-a)
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the demonstration by participants in Item C-2-d.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each demonstration year are located in Item C-2-d. The basis for these estimates is as follows:

ii. Factor D′ Derivation. The estimates of Factor D' for each demonstration year are included in Item C-1. The basis of these estimates is as follows:

iii. **Factor G Derivation**. The estimates of Factor G for each demonstration year are included in Item J-1. The basis of these estimates is as follows:

iv. **Factor G′ Derivation**. The estimates of Factor G' for each demonstration year are included in Item J-1. The basis of these estimates is as follows:

d. Estimate of Factor D.

i. Estimate of Factor D –Complete the following table for each demonstration year

Demonstration Year: Year 1					
Demonstration Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table C-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE DEMONSTRATION					

Demonstration Year: Year 2					
Demonstration Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table C-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE DEMONSTRATION					

Demonstration Year: Year 3					
Demonstration Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table C-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE DEMONSTRATION					

Demonstration Year: Year 4					
Demonstration Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table C-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE DEMONSTRATION					

Demonstration Year: Year 5					
Demonstration Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table C-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE DEMONSTRATION					

Financial Neutrality Demonstration Budget Instructions

Brief Summary

In order for a demonstration to be approved, the State must demonstrate to the satisfaction of CMS that the demonstration is budget neutral during each year that the demonstration is in effect. The demonstration has two components:

- C-1 provides a composite overview of the demonstration that the demonstration is budget neutral
- C-2 contains the basis of the estimates of the factors that make up the budget neutrality demonstration

Financial Neutrality Formula

The equation set forth in 42 CFR §441.303(f)(1) specifies the components of the budget neutrality demonstration. This equation is:

$$\mathbf{D+D' \leq G+G'.}$$

Where:

- The symbol ''≤'' means that the result of the left side of the equation must be less than or *equal* to the result of the right side of the equation.
- D = the estimated annual average per capita Medicaid costs for home and community-based services for individuals in the demonstration program.
- D′ = the estimated annual average per capita Medicaid costs for all other services provided to individuals in the demonstration program.
- G = the estimated annual average per capita Medicaid costs for hospital, nursing facilities, or Immediate Care Facilities for Persons with Mental Retardation care that would be incurred for individuals served in the demonstration, were the demonstration not granted.
- G′ = the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the demonstration, were the demonstration not granted.

This equation takes into account both demonstration services (factor D) and institutional costs (factor G) as well as the costs of furnishing other Medicaid services to demonstration participants (factor D′) and the non-institutional Medicaid costs for persons receiving institutional care (factor G′). For purposes of the equation, the prime factors (D′ and G′) include the average per capita cost for all State plan services and expanded Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) services (when the demonstration covers children) that have been utilized but not accounted for in other formula values.

Also, for purposes of this equation the term "per capita cost" means estimated expenditures during each year of the demonstration divided by the number of *unduplicated* service recipients during each demonstration year. The estimates of per capita costs may not be based on an estimate of the number of "full year equivalents" who will be served each year. Factor D in the equation is derived from the estimates of service utilization and costs in C-2-d (discussed below). Factor D′ is estimated using experience from provision of care to target

population served by this demonstration or other sources of information. Factor G is estimated based on the costs of institutional services for the specific Psychiatric Residential Treatment Facilities (PRTF) level of care specified in under this demonstration. Factor G′ is estimated based on the costs of other Medicaid services furnished to individuals who receive institutional services for the specific PRTF level of care specified under the demonstration. The basis for the estimates of each of these factors were derived is described out in component C-2-c.

For demonstrations that cover individuals with a particular diagnosis or condition, States may utilize target-group specific data. For example, in estimating costs for demonstration participants, a State may estimate the average per capita expenditure for the targeted individuals without including expenditures of other individuals (not meeting targeting criteria) who are inpatients of the institutional comparison group.

Once the demonstration is approved, the State must annually submit financial and statistical information to CMS concerning each equation factor and, in the case of factor D, detailed information concerning service utilization and costs for each service included in the demonstration. This information will be submitted via a Format that will be developed during the Implementation stage of the project.

C-1: Composite Overview and Demonstration of Financial-Neutrality Formula

Overview

This component provides an overview of the budget neutrality demonstration for each demonstration year.

Detailed Instructions for Completion of C-1

Instructions

In the row captioned “level of care,” specify PRTF level of care. For each year the demonstration will be in effect, insert the appropriate values for each budget neutrality formula factor into the table.

Technical Guidance

The value for Factor D inserted into Column 2 of the table must match the estimate of Factor D that is derived in Item C-2-d.

A weighted average is calculated as follows:

- For level of care covered under this demonstration, calculate the total estimated expenditures associated with each factor for each demonstration year. Total estimated expenditures are calculated by multiplying the level-of-care estimate of the formula value for the demonstration year by the unduplicated number of individuals who are expected to utilize the services associated with the formula factor;
- Sum the total estimated expenditures for the formula factor for the demonstration year; and,
- Divide the sum of total expenditures by the sum of the total unduplicated number of

individuals who are expected to utilize the services associated with the formula factor.

The financial report that will be developed during the demonstration Implementation Phase will require reporting each budget neutrality formula factor by level of care and on a composite, weighted average basis.

C-2 - Derivation of Estimates

Overview

In this component, information is provided about how the estimate for each budget neutrality formula factor has been derived. The component also provides for showing the detailed estimate of Factor D.

Detailed Instructions for the Completion of C-2

Item C-2-a: Number of Unduplicated Participants Served

Instructions

In Table C-2-a, insert the total number of unduplicated individuals who will receive demonstration services during each year the demonstration is in effect.

Technical Guidance

The total number of unduplicated demonstration participants who will be served each year the demonstration is in effect is an essential element in calculating Factor D in the budget neutrality formula. The figures included in this table must match the corresponding figures in the year-by-year estimates of Factor D that are derived in item C-2-d.

Item C-2-b: Average Length of Stay

Instructions

In the text field, describe the basis of the estimate of the average length of stay on the demonstration by participants in Item C-2-d.

Technical Guidance

Average length of stay (ALOS) is a statistic that describes the number of days on average during a demonstration year that an individual participates in the demonstration. ALOS can be affected by a variety of factors, including participant turnover (the entry and exit of individuals from the demonstration) and the phase-in or phase-out of the demonstration. ALOS is calculated by dividing the total number of "enrolled days" of all demonstration participants by the unduplicated number of participants

As noted previously, ALOS usually affects the calculation of Factor D in the budget neutrality equation. For example, 220 daily units of a service such as adult day health would be provided to participants who are continuously enrolled throughout the entire demonstration year. However, if the ALOS length of stay on the demonstration is 292 days, then the expected utilization rate of adult day health services per unduplicated participant would be

176 daily units (292/365 = 0.8; 0.8 x 220 = 176). As a general matter, ALOS must be factored in when estimating the utilization of each demonstration service in the calculation of Factor D.

In response to this item, describe the basis of the ALOS estimate that is included in the estimate of Factor D tables in item C-2-d. The basis of the estimate may be based on:

- **Phase-In/Phase-Out Schedule**. When demonstration capacity is being phased-in or phased out, ALOS is affected. For example, if capacity is being phased in, the ALOS estimate will increase each demonstration year until the phase-in is completed.
- **Experience in Similar Demonstrations**. The ALOS estimate may be based on experience in another authority under the Medicaid program or State funded programs that the State (or another State) operates which serves a similar target population.
- **Alternative Basis**. The estimate may be based on the experience of a State-funded program that serves a similar target group or from other data sources. Provide a complete description of the information that was employed to estimate the ALOS.

However the ALOS estimate is derived, provide a complete description of the basis of the estimate.

Item C-2-c: Derivation of Estimates of Each Factor

In this item, the derivation for the estimates of each factor in the budget-neutrality formula is specified.

For demonstrations that apply only to individuals with a specific illness or condition, estimates that are based only on the particular group may be used. As necessary and appropriate, include references to supporting documentation for how these values were derived. As necessary, CMS may request that the State supply the supporting documentation through the Medicaid agency and/or the operating agency (if applicable).

Item -i: Factor D Derivation

Instructions

In the text field, describe the basis of the estimates of Factor D.

Technical Guidance

The Factor D value is calculated by completing the tables contained in item C-2-d. See also the instructions for completing Item C-2-d. Here, provide a complete explanation of the how the values (except for ALOS and the unduplicated number of participants) contained in that table were derived.

The Factor D estimate is derived by estimating: (a) the unduplicated number of participants who are expected to utilize each demonstration service; (b) the number of units of services these participants are expected to utilize during a demonstration year (taking into account ALOS); and, (c) the expected average unit cost of each demonstration service. These elements lead to the calculation of the total estimated cost for each demonstration service. These service-by-service costs are summed and divided by the total number of unduplicated demonstration participants for the demonstration year in order to estimate Factor D.

The explanation of the derivation of the Factor D estimate must include the basis of the estimates for: (a) the estimated number of service users; (b) the estimate of the number of units/user; and, (c) the average per unit cost. In particular:

- **Estimated number of users**. Under this demonstration, the estimate should be based on actual experience as experienced by the State (e.g., the percentage of demonstration participants who utilize a service), modified as appropriate to take into account changes in the number of persons who will be served during the demonstration period.
  Units/User. The utilization rate must be reasonably estimated based on needs of the target population and the average length of stay. If the estimated number of units/user departs from the previous actual experience, explain and justify the basis of the deviation.
- **Costs/Unit**. Under this demonstration the estimate should be based on actual experience of the State. If the estimated number of users departs from the previous actual experience, explain and justify the basis of the deviation.

  The source may be a State study, utilization of similar services in other demonstration programs, or experience in other States. The explanation must identify the factor or factors that were used to trend unit costs forward across all demonstration years. If a particular service has several intensity levels or settings and associated unit costs, the explanation of the derivation of unit costs should include information about each level (i.e., the derivation of the weighted average unit costs included in the table in item C-2-d).

Item C-2-c-ii: Factor D' Derivation

Instructions

In the text field, describe the basis of the estimates of Factor D′.

Technical Guidance

Factor D′ is the estimated annual average per capita Medicaid costs for all services (State plan and expanded EPSDT services (when a demonstration serves children) that are furnished in addition to demonstration services while the individual is in the demonstration. This calculation includes institutional costs when a person leaves the demonstration for the institution and returns to the demonstration in the same demonstration year. If a demonstration participant does not return to the demonstration following institutionalization, do not include the budget of institutional care under D′. Do not include institutional costs incurred before the person is admitted into the demonstration. If institutional respite care is provided as a service under this demonstration, calculate its costs under Factor D. Do not duplicate these costs in the calculation of Factor D′. If a demonstration service is covered under the State plan and the service is defined identically except for utilization limits, the State plan service, up to the imposed limit, would be included under D′. The services under the demonstration that exceed the State plan utilization limits would be included under factor D as demonstration costs.

Include an explanation of how the D′ value is derived. In general, the D′ value must be greater than or equal to the G′ value. Typically, institutional payments encompass the costs of health care services that are furnished to institutional residents and, therefore, included in Factor G. In the case of demonstration participants, most health care services are obtained via the State plan. If factor D′ is less than factor G′, provide an explanation of the reasons why this is the case. This situation may arise when institutional payments do not encompass all services that are furnished to institutional residents. Factor D′ may be computed using statistically valid methods. If the D′ is developed through sampling a comparable population, provide information on the process used and how the D′ value was derived.

Item C-2-c-iii: Factor G Derivation

Instructions

In the text field, describe the basis of the estimates of Factor G.

Technical Guidance

The Factor G value must reflect the average costs for the PRTF institutional level of care that would otherwise be furnished to demonstration participants. If institutional respite care is provided as a service under the demonstration calculate its costs under Factor D. Do not duplicate these costs in the calculation of Factor G.

When budget-neutrality estimates are based on the comparison of community costs to institutional costs and the State does not wish to base its estimate of institutional costs on the costs of serving individuals with specific illnesses or conditions, the projected first year and subsequent year Factor G values through the end of the demonstration must be based on the actual costs of institutional services for all individuals at the relevant PRTF level of care for the most recent year for which such data are available. These actual costs may be trended forward by applying inflation adjustments based on the current Medical Consumer Price Index unless higher rates are justified or the State employs a different basis for estimating future costs (e.g., observed State trends in the costs of institutional services). Specify the source of the data upon which the estimate of Factor G are based and how those costs are adjusted year-by-year.

Item C-2-c-iv: Factor G' Derivation

Instructions

In the text field, describe the basis of the estimates of Factor G′.

Technical Guidance

Factor G′ includes the costs of all other Medicaid services furnished while the individual is institutionalized (including State plan and expanded EPSDT services) and the costs of short term hospitalization (furnished with the expectation that the person would return to the institution). When the demonstration serves children, the G′ value includes expanded EPSDT services that are not accounted for in the G value. When institutional respite care is provided as a service under this demonstration, calculate its budget under Factor D. Do not duplicate these costs in the calculation of Factor G′.

Explain how the G′ value is derived, including any supporting documentation. The projected first year G′ value should not deviate substantially from previous year trends unless the State has altered its Medicaid program. Inflation adjustments should reflect data in current Medicaid Consumer Price Index unless other rates are justified.

Medicare/Medicaid dual eligibles under the provisions of Part D. To the extent that such costs are included in baseline CMS-372(S) figures, they must be removed. The explanation of the derivation of Factor G′ must describe how the State has accounted for and removed the costs of these prescribed drugs from its estimate.

Item C-2-d: Estimate of Factor D

Instructions

C-2-d-i:

The table must be completed for each year that the demonstration is in effect. The services listed in the table must match the list of services specified in Attachment 6. When a service listed in Attachment 6 encompasses two or more discrete services that are reimbursed separately, the discrete services must be shown in the table. When a service in Attachment 6 is a bundled service, each component of the service must be shown.

With respect to column 1, the unit of service (for example, day, hour, month, trip, etc.) must be identified for each service. With respect to column 3, keep in mind that the estimated number of units per user must reflect the estimated ALOS rather than the potential maximum number of service units that a participant may utilize.

The average cost per unit (column 4) must be reasonably estimated. The estimate must be based on expected payment rates for the service. When payment rates vary, the estimate should be based on the expected mix of payment rates.

The figures in this table should follow these rules:

- **Average Number of Users.** The average number of users must be expressed as a whole number (i.e., 235 users not 234.8 users);
- **Average Number of Units per User**. Express as a whole number.
- **Average Cost Per Unit**. Express in dollars and cents.
- **Total Cost**. Total cost is expressed as the product of the average number of users, the average number of units per user and the average cost per unit.

The figures in the table may be developed by preparing a spreadsheet. However, when the spreadsheet values are transferred to the table, they must be modified to reflect the foregoing arithmetic rules. This will avoid issues that might arise as a result of rounding algorithms in the underlying spreadsheets.

ATTACHMENT 6

Home and Community-Based Services Core Services Definitions

To learn more about the new HCBS waiver application, visit http://www.cms.hhs.gov/HCBS/02_QualityToolkit.asp#TopOfPage and click on HCBS Waiver Application [Version 3.3][ZIP 2.0MB]link. References to all appendices can be found in the HCBS waiver application

A. Statutory Services

Statutory services are services specifically mentioned in §1915(c) of the Act and 42 CFR §440.180. They also are listed in the first section of Appendix C-1 of the application. Core service definitions are provided for each of these services. As discussed in the instructions for Appendix C-1, a waiver is considered to cover a statutory service as long as the State's definition aligns with the core service definition included here, even though an alternate title is used (e.g., "support coordination" instead of "case management" or "attendant care" instead of "personal care").

1. Case Management

Core Service Definition:

Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Instructions

- When case managers perform other activities/functions (e.g., crisis response) that are not included in the core definition, specify the additional activities/functions.
- When case managers are responsible for the ongoing monitoring of the provision of services included in the participant's service plan and/or participant health and welfare, include a statement to that effect in the service definition.
- When case managers are responsible for initiating process of assessment and reassessment of the individual's level of care and/or the development of service plans as specified in Appendices B & D of the application, include a statement to that effect in the service definition.
- When the State claims the cost of case management furnished to institutionalized individuals prior to their transition to the waiver (as provided in Olmstead Letter No.3 (see Attachment D)), include a statement to that effect in the service definition. Case management services to facilitate transition to the community furnished up to 180 days prior to transition may be claimed for Federal financial participation as a waiver service. Specify the period that such services may be furnished, not to exceed 180 days. Providers may bill for this service on the date of the person's entry into the waiver program.
- When case management includes providing supports to assist participants to direct their services, specify the types of supports that case managers furnish. For example, a case manager may have responsibility for monitoring the expenditure of funds included in the participant-directed budget when the Budget Authority opportunity is provided under the waiver.

Guidance

- When case management is furnished as a waiver service, a State may not limit the providers of case management to specific classes of entities (e.g., county human services agencies). All willing and qualified providers must be offered a provider agreement. Participants must be able to select from among all qualified providers.
- When activities related to the assessment of level of care and service plan development are furnished as waiver case management activities, payment for such services may not be made until the individual is actually enrolled in the waiver.
- The scope of case management services may not include activities/services that constitute the provision of direct services to the participant that normally are covered as distinct services (e.g., the transportation of individuals to sites to where waiver services are furnished or to receive State plan services). When case managers furnish direct services, the costs of the services must be billed to the appropriate service coverage (e.g., State plan transportation).

2. Homemaker Services

Core Service Definition:

Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Instructions

- If homemaker services include other activities/functions that are not reflected in the core definition, modify the core definition to specify the activities/ functions.
- If homemaker services are limited to the performance of a specific set of household tasks, list the specific tasks in the definition.

Guidance

- Homemaker services are distinguished from personal care services. Personal care services include assistance in activities of daily living whereas homemaker services usually are confined solely to the performance of household tasks.
- The core service definition may be modified to include the performance of "chore-type" services by a homemaker. See the definition of chore services below.

3. Home Health Aide Services

Background

Home health services are a mandatory State plan service. Home health aide services are a component of the State plan coverage. In a waiver, a State may elect to furnish home health aide services that are different in their scope and nature than the services offered under the State plan. Alternatively, if there are limitations on the amount, frequency and duration of the provision of home health aide services in the State plan, a State may elect to provide additional services over and above those permitted under the State plan. Two alternative core service definitions are provided depending on how the State elects to cover home health

aide services under the waiver.

Core Service Definition *(Services differ in scope and nature from the State plan)*:

Services defined in 42 CFR §440.70 that are provided in addition to home health aide services furnished under the approved State plan. Home health aide services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from home health aide services in the State plan. The differences from the State plan are as follows:

Core Service Definition *(Extended State Plan Service)*:

Services defined in 42 CFR §440.70 that are provided when home health aide services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from home health aide services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is as follows:

Instructions

- If the only difference between the coverage of home health aide services under the State plan and the waiver is that waiver services supplement State plan services over and above State plan limitations on amount, duration, and frequency, use the home health aide services "extended State plan service" definition above. For example, if the State plan limits home health aide services to no more than 10 visits per month but the State wishes to provide for additional visits for waiver participants, use the extended State plan service definition. Specify the additional services that are provided when the State plan benefit is exhausted.
- When the scope and nature of home health aide services under the waiver differ from the coverage under the State plan, use the first core definition and specify how the scope and nature of services differs from the State plan, including the other activities/functions that home health aides perform in addition to those specified under the State plan.

Guidance

- If home health aide services may be furnished outside the participant's home, include a statement to that effect in the service definition. This is an example of how the scope of coverage may differ from the State plan.
- One source of difference between the coverage of home health aide services under the State plan and the waiver may arise from provider qualifications. Home health services (including home health aide services) under the State plan may only be furnished by home health agencies that meet the requirements for participation in Medicare, as provided in 42 CFR §489.28.
- The coverage of home health aide services under a waiver does not permit a State to restrict access by waiver participants to home health services that are offered under the State plan. Waiver participants are entitled to receive all benefits for which they are eligible under the State plan.
- Home health aide services that can be covered under the State plan should be furnished to waiver participants under age 21 as expanded EPSDT benefits rather than through the waiver.

4. Personal Care

Background

Personal care services are an optional benefit that a State may furnish under its State plan, as provided in 42 CFR §440.167. A State may offer personal care under a waiver when: (a) it does not offer personal care under its State plan; (b) its coverage under the waiver differs in scope and nature from the coverage under the State plan; or, (c) the State wishes to furnish personal care services in an amount, duration, or frequency that exceed the limits in the State plan. Two core service definitions are provided:

Core Service Definition *(Services differ in scope and nature from personal care under the State plan or personal care is not provided under the State plan)*:

> *A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law.*

Core Service Definition *(Extended State Plan Service)*:

> *Services that are provided when personal care services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from personal care services furnished under the State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is as follows:*

Instructions

- If personal care under the waiver is furnished to supplement personal care under the State plan but otherwise the scope of the coverage and who may provide the service is the same as under the State plan, use the "extended State plan service" core definition. Specify the additional amount of services that may be provided under the waiver.
- When personal care services are not provided under the State plan, use the first core definition.
- When personal care is covered under the State plan but the scope and nature of personal care furnished to waiver participants differs from the State plan, also use the first core definition and include the following statement: *"Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the State plan."* Also, specify the differences between the waiver coverage and the State plan coverage.
- When the first core definition is used, as appropriate, supplement the core definition by specifying the types of assistance furnished. Such assistance may include assistance in performing Activities of Daily Living (bathing, dressing, toileting, transferring, maintaining continence) and Independent Activities of Daily Living (more complex life activities) (e.g., personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication and money management). Such assistance also may include the supervision of participants as provided in the service plan.
- If personal care is furnished outside the participant's home, include a statement to that effect in the first core definition.

- Also with respect to the first core definition, when individuals who are not employed by a provider agency may provide personal care, the service definition must specify who oversees and supervises these individual providers (e.g., a registered nurse, case manager, and/or the participant) and the frequency of supervision.
- When personal care may be participant-directed, specify in the service definition the responsibilities and authority of the participant to direct the delivery of personal care.
- Personal care may be furnished to escort participants to participate in community activities or access other services in the community. However, the transportation costs associated with the provision of personal care outside the participant's home must be billed separately and may not be included in the scope of personal care. Personal care aides may furnish and bill separately for transportation provided that they meet the State's provider qualifications for transportation services, whether medical transportation under the State plan or non-medical transportation under the waiver.

Guidance

- Alternate service titles may be employed for personal care, including personal assistance and attendant care.
- It is not necessary to reflect in the service definition pertinent policies that apply to the provision of personal care by legally responsible individuals or other family members/legal guardians. These topics are addressed in the responses to Items C-2-d and C-2-e in Appendix C-2 of the application.
- The scope of personal care may include performing incidental homemaker and chore services tasks. However, such activities may not comprise the entirety of the service.
- When the provision of personal care is included in the scope of another covered service (e.g., residential habilitation or assisted living), a State may prohibit the provision of personal care as a distinct additional service when a waiver participant receives the other covered service that includes personal care.
- Personal care may be furnished in order to assist a person to function in the work place or as an adjunct to the provision of employment services.
- When personal care services are offered under the State plan, a State may not restrict the access of waiver participants to such services.
- Personal care services that can be covered under the State plan should be furnished to waiver participants under the age of 21 as expanded EPSDT benefits.

5. Adult Day Health

Core Service Definition

Services generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Instructions

- Supplement or modify the core definition as appropriate to encompass specific service elements/activities furnished as adult day health under the waiver.
- If physical, occupational and/or speech/language therapies included in the participant's service plan are furnished as components of this service, include a statement to that

effect in the definition.

- If transportation between the participant's place of residence and the adult day health site is provided as a component of adult day health services and the cost of this transportation is included in the rate paid to adult day health providers, include a statement to that effect in the definition.
- While adult day health services generally are provided for 4 or more hours per day, they may be furnished for fewer hours. It also is not required that participants receive adult day health services each day.

Habilitation Services

General Guidance

Habilitation may be covered as a distinct waiver service. Usually, however, the coverage of habilitation takes the form of the coverage of day and residential habilitation as separate services. In addition, States may cover enhanced habilitation services (supported employment, education, and prevocational services). In general, when enhanced habilitation services are covered, they must be covered as distinct services rather than combined as a single service. Core definitions are provided for habilitation, residential habilitation, day habilitation, prevocational, supported employment, and education.

While habilitation is frequently identified with the provision of services to persons with mental retardation and other related conditions, habilitation services (including enhanced habilitation services) may be furnished to other target groups (e.g., persons who have experienced a brain injury) who may benefit from them. Services that are habilitative in nature may not be covered under the State Plan except in an ICF/MR.

6. Habilitation

Core Service Definition

Services designed to assist participants in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Instructions:

- Supplement or modify the core definition as appropriate to specify the specific service elements/activities that are furnished as habilitation under the waiver.
- Specify the settings in which habilitation is furnished.

Guidance

- Habilitation may be furnished in any appropriate community setting.
- When habilitation is provided as a single service (rather than broken down into component parts), the provider qualifications specified must not have the effect of unnecessarily limiting the providers of the service.

7. Residential Habilitation

Core Service Definition:

Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill

development that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision.

Payment is not be made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix J. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as provided in Appendix C-2.

Instructions

- Supplement or modify the core definition as appropriate to encompass the specific service elements/activities furnished as residential habilitation.
- Residential habilitation may be furnished in the following living arrangements: participant's own home, the home of a relative, a semi-independent or supported apartment or living arrangement, or a group home. Supplement the core definition by specifying the types of settings where residential habilitation is furnished.

Guidance

- Residential habilitation services may be provided in the participant's living arrangement or in the surrounding community, provided that such services do not duplicate services furnished to a participant as other types of habilitation.
- Provider owned or leased facilities where residential habilitation services are furnished must be compliant with the Americans with Disabilities Act.
- Home accessibility modifications when covered as a distinct service under the waiver may not be furnished to individuals who receive residential habilitation services except when such services are furnished in the participant's own home. Compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes may be included in provider rate (as amortized costs) so long as they are necessary to meet the needs of residents and are not basic housing costs.
- Residential habilitation services may include the provision of medical and health care services that are integral to meeting the daily needs of residents (e.g., routine administration of medications by nurses or tending to the needs of residents who are ill or require attention to their medical needs on an ongoing basis). The provision of such routine health services and the inclusion of the payment for such services in the payment for residential habilitation services are not considered to violate the requirement that a waiver may not cover services that are available through the State plan. Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents may not be included.
- Personal care/assistance may be a component part of residential habilitation services but may not comprise the entirety of the service. When personal care is covered as a distinct waiver service but also is furnished as a component of residential habilitation, there must be mechanisms that prevent the duplicative billing of the provision of personal care services.
- If transportation between the participant's place of residence and other service sites or places in the community is provided as a component of residential habilitation services and the cost of this transportation is included in the rate paid to providers of residential habilitation services, include a statement to that effect in the service definition.
- When residential habilitation services are furnished in living arrangements subject to

§1616(e) of the Social Security Act (the Keys Amendment), the standards for such services must address the topics specified in Appendix C-2 (item C-2-c-ii), including assuring that the living arrangement is homelike rather than institutional in character.

8. Day Habilitation

Core Service Definition:

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week, or as specified in the participant's service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings.

Instructions

- Supplement or modify the core definition as appropriate to specify service elements/activities furnished as day habilitation under the waiver.
- Day habilitation may be furnished in any of a variety of settings in the community. Day habilitation services are not limited to fixed-site facilities. Supplement the core definition by specifying where day habilitation is furnished.
- If transportation between the participant's place of residence and the day habilitation site is provided as a component part of day habilitation services and the cost of this transportation is included in the rate paid to providers of day habilitation services, the service definition must include a statement to that effect in the definition.

Guidance

- Day habilitation may not provide for the payment of services that are vocational in nature (e.g., sheltered work).
- Personal care/assistance may be a component part of day habilitation services as necessary to meet the needs of a participant but may not comprise the entirety of the service.
- Participants who receive day habilitation services may also receive educational, supported employment and prevocational services. A participant's service plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.
- Day habilitation services may be furnished to any individual who requires them. They are not limited to persons with mental retardation or developmental disabilities.
- For individuals with degenerative conditions, day habilitation may include training and supports designed to maintain skills and functioning and to prevent, or slow, regression.

9. Education

Core Service Definition:

Educational services consist of special education and related services as defined in sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA. Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.

Instructions

- If transportation between the participant's place of residence and the educational services site is provided as a component of education services and the cost of this transportation is included in the rate paid to providers of education services, include a statement to that effect in the service definition.
- Supplement or modify the core definition as appropriate to specify the service elements/activities that are furnished under the waiver and where education services are furnished.
- Supplement the core definition to specify the process by which it will be determined that education services do not fall within the requirements of the IDEA.

Guidance

- The IDEA requires the provision of comprehensive education and related services to children and youth with disabilities who are enrolled in special education programs. As a consequence, when a State proposes to include education services in its waiver, CMS will review the proposed waiver coverage to ensure that it does not provide for the payment of services that are mandated under IDEA.
- §1903(c)(3) of the Act permits Medicaid payment for services included in an eligible child's Individualized Education Plan (IEP). However, this provision is limited to services that are provided under the State plan and does not include services that are furnished under the §1915(c) waiver authority. Consequently, HCBS waiver Federal financial participation (FFP) may not be claimed for services included in a child's IEP.

10. Prevocational Services

Core Service Definition:

Services that prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Services are not job-task oriented, but instead, aimed at a generalized result. Services are reflected in the participant's service plan and are directed to habilitative rather than explicit employment objectives. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Instructions

- Supplement or modify the core definition as appropriate to incorporate the specific service elements furnished under the waiver.
- Prevocational services may be furnished in a variety of locations in the community.

Specify in the service definition where these services are furnished.

- If transportation between the participant's place of residence and the prevocational services site is provided as a component part of prevocational services and the cost of this transportation is included in the rate paid to providers of prevocational services, the service definition must include a statement to that effect.
- Specify in the definition how the determination is made that the services furnished to the participant are prevocational rather than vocational in nature in accordance with Federal regulations at 42 CFR §440.180(c)(2)(i).

Guidance

- Vocational services are services that teach specific skills required by a participant to perform tasks associated with performing a job. Prevocational services address underlying generalized habilitative goals (e.g., attention span, motor skills) that are associated with performing compensated work. Participants who receive prevocational services may be compensated in accordance with applicable Federal laws and regulations. The following criteria ***may*** be used to differentiate between prevocational and vocational services. However, the presence of one or more common criteria (such as service participants receiving compensation exceeding 50 percent of minimum wage) should not be interpreted as equating prevocational and vocational services. Rather than disqualifying the individual from service eligibility, these criteria may be used as a "trigger" for a review of the necessity and adequacy of the service.
    - Prevocational services are provided to persons who are not expected to join the general work force or participate in a transitional sheltered workshop within one year of service initiation (excluding supported employment programs).
    - If compensated, individuals are paid at less than 50 percent of the minimum wage.
    - Services include activities that are not primarily directed at teaching job-specific skills but at underlying habilitative goals (e.g., attention span, motor skills).
- Personal care/assistance may be a component of prevocational services, but may not comprise the entirety of the service.
- Individuals receiving prevocational services may also receive educational, supported employment and/or day habilitation services. A participant's service plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.
- Prevocational services may be furnished to any individual who requires them. They are not limited to persons with mental retardation or related conditions.

11. Supported Employment

Core Service Definition

Supported employment services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and

training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. *Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;*
2. *Payments that are passed through to users of supported employment programs; or*
3. *Payments for training that is not directly related to an individual's supported employment program.*

Instructions

- Supplement or modify the core definition as appropriate to incorporate the specific service elements furnished in the waiver.
- Specify where in the community supported employment is furnished.
- If transportation between the participant's place of residence and the employment site as a component part of supported employment services and the cost of this transportation is included in the rate paid to providers of supported employment services, the service definition must include a statement to that effect.

Guidance

- Supported employment does not include sheltered work or other similar types of vocational services furnished in specialized facilities.
- Supported employment services may be furnished to participants who are paid at a rate more than the minimum wage, provided that the participant requires supported employment services in order to sustain employment.
- Supported employment services may be furnished by a co-worker or other job-site personnel provided that the services furnished are not part of the normal duties of the co-worker or other personnel and these individuals meet the pertinent qualifications for the providers of service.
- Personal care/assistance may be a component part of supported employment services but may not comprise the entirety of the service.
- Supported employment may include services and supports that assist the participant in achieving self-employment through the operation of a business. However, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Such assistance may include: (a) aiding the participant to identify potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and (d) ongoing assistance, counseling, and guidance once the business has been launched.
- Individuals receiving supported employment services may also receive educational, prevocational, and/or day habilitation services. A participant’s service plan may include

two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.

- Supported employment services may be furnished to any individual who requires them. They are not limited to persons with developmental disabilities.

12. Respite Care

Core Service Definition:

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. FFP is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Instructions:

- Supplement or modify the core definition, as appropriate, to incorporate specific service elements under the waiver.
- The service definition must specify the location(s) where respite care is provided. These locations may include (but are not limited to):
    - Participant's home or private place of residence
    - The private residence of a respite care provider
    - Foster home
    - Medicaid certified Hospital
    - Medicaid certified Nursing Facility
    - Medicaid certified ICF/MR
    - Group home
    - Licensed respite care facility
    - Other community care residential facility approved by the State that is not a private residence. Specify the types of these facilities where respite is provided.
- The service definition must specify the location(s) (if any) where FFP is claimed for the cost of room and board. FFP may not be claimed for room and board when respite is provided in the participant's home or place of residence.

Guidance

- Receipt of respite care does not necessarily preclude a participant from receiving other services on the same day. For example, a participant may receive day services (such as supported employment, adult day care, personal care, nursing care, etc.) on the same day as he/she receives respite care. Payment may not be made for respite furnished at the same time when other services that include care and supervision are provided.
- Respite care may be made available to persons who receive residential habilitation or other types of residential services under the waiver (e.g., adult foster care) for the relief of a primary caregiver, provided that there is no duplication of payment. When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite care may not be furnished for the purpose of compensating relief or substitute staff for a waiver residential service. The costs of such staff are met from payments for the waiver residential service.

Mental Health Services

Federal regulations at 42 CFR §440.180(b)(8) provide that a State may furnish under a waiver certain services (day treatment, partial hospitalization, psychosocial rehabilitation, and clinic services) to individuals with chronic mental illness. A State may offer other types of mental health services in addition to these as "other" waiver services. However, the provision of mental health services under a waiver is not limited to persons who have a primary diagnosis of chronic mental illness. They may be furnished to any participant who requires them, regardless of waiver target group. As is the case with other services, mental health services under a waiver may be furnished on an "extended State plan services" coverage basis or may provide for the coverage of services furnished that differ from State plan services.

Mental health services offered under the State plan sometimes are limited to Medicaid beneficiaries who have been diagnosed as having serious (severe or persistent) mental illnesses. Under a waiver, a State may offer mental health services to persons who would benefit from them, but who do not meet State plan criteria.

When a State proposes to cover mental health services under a waiver, CMS will review the State plan to ensure that the proposed coverage does not duplicate the coverage under the State plan. In the case of waivers that serve individuals under age 21, this review also will encompass the extent to which the proposed mental health services can be provided under the State plan and, therefore, should be furnished as expanded EPSDT benefits.

13. Day Treatment

Core Service Definition:

Services that are necessary for the diagnosis or treatment of the individual's mental illness. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law);
b. occupational therapy, requiring the skills of a qualified occupational therapist;
c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness;
d. drugs and biologicals furnished for therapeutic purposes, provided that the medication is not otherwise available under the State plan or as a Medicare benefit to a participant;
e. individual activity therapies that are not primarily recreational or diversionary;
f. family counseling (the primary purpose of which is treatment of the individual's condition);
g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment); and,
h. diagnostic services.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Core Service Definition *(Extended State Plan Service)*

When day treatment or partial hospitalization services are covered under the waiver on an "extended State plan service" basis (e.g., the services furnished differ from the State plan

coverage only in amount, duration, and frequency, but not scope or type of provider), employ the following alternate service core service definition:

Services that are provided when day treatment services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from day treatment services furnished under the State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is as follows:

Instructions:

- Supplement or modify the core definition's list of service elements as appropriate to reflect the specific service elements covered under the waiver.
- If transportation between the participant's place of residence and the day treatment is provided as a component part of day treatment/partial hospitalization services and the cost of this transportation is included in the rate paid to providers of these services, include a statement to that effect in the service definition.
- In the definition, specify whether these services are only furnished to individuals with chronic mental illness or whether they are available to all individuals served on this waiver who may require them, whether or not they have a formal diagnosis of chronic (serious) mental illness.
- If day treatment services are covered under the State plan but the waiver coverage is different, include the following statement in the service definition: *"Day treatment (partial hospitalization) services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from day treatment (partial hospitalization) services in the State plan."* Also, specify the differences between the waiver and the State plan coverage. If day treatment or partial hospitalization is not covered under the State plan, do not include this statement.

14. Psychosocial Rehabilitation Services

Core Service Definition:

Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management, and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention rather than diversion); and,

d. telephone monitoring and counseling services.

The following are specifically excluded from payment for psychosocial rehabilitation services:

a. vocational services,
b. prevocational services,
c. supported employment services, and
d. room and board.

Core Service Definition *(Extended State Plan Service)*

When psychosocial rehabilitation services are covered under the waiver solely on an "extended State plan service" basis (e.g., the services furnished differ from the State plan coverage only in amount, duration, and frequency, but not scope or type of provider), use the following alternate service core service definition:

> *Services that are provided when psychosocial rehabilitation services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from psychosocial services furnished under the State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is as follows:*

Instructions

- Supplement or modify the core definition list of service elements, as appropriate, to reflect the specific service elements covered under the waiver.
- In the definition, specify whether these services are only furnished to individuals with chronic mental illness or whether they are made available to all waiver participants who need the service, whether or not they have a formal diagnosis of chronic (serious) mental illness.
- Psychosocial rehabilitation services may be furnished in any of a variety of locations in the community, including the participant's own home, provider-operated living arrangements and other community settings. In the service definition, specify where these services will be furnished. When services are furnished in a residence, FFP may not be claimed for the cost of room and board.
- If psychosocial rehabilitation services (mental health rehabilitation services) are covered under the State plan but the waiver coverage is different, include the following in the service definition: *"Psychosocial rehabilitation services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from psychosocial rehabilitation services in the State plan."* Also specify the differences between the waiver coverage and the State plan coverage. If psychosocial rehabilitation services are not covered under the State plan, do not include this statement.

Guidance

- The term "psychosocial rehabilitation services" subsumes the various types of mental health services that may be covered as rehabilitative services in the State plan under 42 CFR §440.130.
- Participants who are furnished psychosocial rehabilitation services may be provided prevocational and/or supported employment services when such services are included in the waiver as enhanced habilitation services. However, these services may not be combined with psychosocial rehabilitation services.

15. Clinic Services

Core Service Definition:

Clinic services (whether or not furnished in a facility) are services as defined in

42 CFR §440.90.

Instructions

- In the definition, specify whether these services are only furnished to individuals with chronic mental illness or whether they are made available to all individuals served on this waiver, whether or not they have a formal diagnosis of chronic (serious) mental illness.
- In the definition, specify whether clinic services may only be furnished on the premises of a clinic or may be furnished outside the clinic facility. If services may be furnished offsite, specify the locations where they may be furnished.
- If (mental health) clinic services are covered under the State plan but the waiver coverage is different, include the following statement in the service definition: *"Clinic services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from clinic services in the State plan."* Also specify the differences between the waiver coverage and the State plan coverage. One way that the coverage of clinic services under the waiver may differ from coverage under the State plan is when services are furnished off-site from the clinic. Describe the difference between the waiver and the State plan coverage.
- When mental health clinic services are covered under the waiver only on an "extended State plan service" basis (e.g., the services furnished differ from the State plan coverage only in amount, duration and frequency but not scope), employ the following alternate service core service definition:

  #### Core Service Definition *(Extended State Plan Service)*

  Services that are provided when mental health clinic services (as defined at 42 CFR §440.90) furnished under the approved State plan limits are exhausted. The scope and nature of these services do not otherwise differ from clinic services furnished under the State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is as follows: (specify)

16. Live-in Caregiver

Core Service Definition:

The payment for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. How the amount that is paid is determined is specified in Appendix I-6. Payment will not be made when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

Instructions

- In the revised waiver application, live-in caregiver is treated as a service that must be included in the listing of services in Appendix C-1.
- The expected costs and utilization of live-in caregiver payments must be accounted for as a distinct item in the computation of Factor D in Appendix J-2.

B. Other Services

Other services are services that are not: (a) statutory services; (b) extended State plan services; or, (c) services in support of participant direction.

1. Home Accessibility Adaptations (a.k.a., environmental accessibility adaptations)

Core Service Definition:

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant, or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Instructions

- Supplement or modify the core definition list of service elements as appropriate to reflect the specific service elements covered under the waiver.
- An exhaustive listing of the specific adaptations may be included in the definition rather than the more general types of adaptations contained in the definition. In the core definition, the sentence beginning "Such adaptations …" may be deleted and the sentence "Adaptations include:" substituted, followed by the exhaustive listing of the specific home adaptations included in the coverage.
- The scope of home accessibility modifications may include the performance of necessary assessments to determine the types of modifications that are necessary.

Guidance

- Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
- When, as provided in Olmstead Letter No. #3 (see Attachment D to the Instructions), the State authorizes home accessibility modifications up to 180-days in advance of the community transition of an institutionalized person, and the definition should reflect that provision has been made for such modifications. In such cases, the home modification begun while the person was institutionalized is not considered complete until the date the individual leaves the institution and enters the waiver.

2. Vehicle Modifications

Core Service Definition:

Adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the

health, welfare, and safety of the participant. The following are specifically excluded:

1. *Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;*
2. *Purchase or lease of a vehicle; and*
3. *Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications.*

Instructions

- Modify or supplement the core definition to reflect the scope of vehicle modifications furnished under the waiver. If such modifications are limited to specific modifications, list the modifications for which payment will be made.
- The scope of vehicle modifications may include the performance of necessary assessments to determine the types of modifications that are necessary.

Guidance

- The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.
- Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services. The costs of necessary adaptations to provider vehicles may be compensated in the payment rate for transportation or other services (e.g., day habilitation) that include the cost of transportation.

3. Non-Medical Transportation

Core Service Definition:

Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Instructions

- Modify or supplement the core definition to reflect the scope of non-medical transportation furnished under the waiver.
- If transportation services are limited to specific situations, specify when transportation services are furnished in the definition.

Guidance

- Waiver transportation services may not be substituted for the transportation services that a State is obligated to furnish under the requirements of 42 CFR §431.53. For example, transportation of a waiver participant to receive medical care that is provided under the

State plan must be billed as a State plan transportation service or charged as an administrative expense, not as a waiver service. Payment for transportation under the waiver is limited to the costs of transportation needed to access a waiver service included in the participant's service plan or access other activities and resources identified in the service plan.

- When the costs of transportation are included in the provider rate for another waiver service (e.g., adult day health), there must be mechanisms to prevent the duplicative billing of non-medical transportation services.
- Non-medical transportation services may be furnished to waiver participants under age 21.

4. Specialized Medical Equipment and Supplies

Core Service Definition

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan . Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design, and installation.

Instructions

- Modify or supplement the core definition to reflect the scope of medical equipment and supplies furnished under the waiver.
- When coverage is limited to specific supplies or equipment, include a listing in the definition.
- If the coverage includes the costs of maintenance and upkeep of equipment, include a statement to that effect in the definition.
- When the coverage includes training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply, include a statement to that effect in the definition.
- If the coverage includes the performance of assessments to identify the type of equipment needed by the participant, include a statement to that effect in the definition.

Guidance

- This coverage may be used to supplement the items that the State makes available under its coverage of Durable Medical Equipment or medical supplies under the State plan.
- States have employed this coverage to furnish a wide variety of adaptive positioning devices, mobility aids, and adaptive equipment.
- The coverage also may include augmentative communication devices and services or such services may be covered as a distinct service.

- Medical equipment and supplies that can be covered under the State plan should be furnished as expanded EPSDT benefits to waiver participants under age 21.

5. Assistive Technology

Core Service Definition:

Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes--

(A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;

(E) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
(F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Instructions

Modify or supplement the core definition to reflect the scope of assistive technology services and devices furnished under the waiver. If such devices and/or services are limited to specific types, list the types for which payment will be made.

6. Personal Emergency Response System (PERS)

Core Service Definition:

PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein.

Instructions

- Supplement or modify the core definition as appropriate to reflect the specific covered devices and services under the waiver.
- If installation, upkeep and maintenance of devices/systems are provided, include a

statement to that effect in the definition.

7. Community Transition Services

Core Service Definition:

Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household, that does not constitute room and board, and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, and arrange for and procure needed resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense, or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Instructions

- Supplement or modify the core definition, as appropriate, to reflect the specific community transition services that are included under the waiver.
- The service definition may be modified as necessary to reflect specific items and services that are included or excluded.
- Community Transition Services may not include payment for room and board. The payment of a security deposit is not considered rent.

Guidance

- See State Medicaid Director Letter #02-008 (Attachment D to Instructions) for further information.
- When Community Transition Services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for, and to enroll in, the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition); transitional services may be billed to Medicaid as an administrative cost.
- At the State's option, Community Transition Services may be furnished as a waiver service to individuals who transition from provider-operated settings (other than

Medicaid reimbursable institutions) to their own private residence in the community.

- Community Transition Services may not be used to furnish or set up living arrangements that are owned or leased by a waiver provider.

8. Skilled Nursing

Core Service Definition:

Services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

Instructions

- If skilled nursing services are limited to specific types of nursing services, specify the types of services in the definition.
- If skilled nursing services are covered under the State plan but the waiver coverage is different, include the following statement in the service definition: *"Skilled nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from skilled nursing services in the State plan."* Also specify the differences between the waiver coverage and the State plan coverage. If skilled nursing services are not covered under the State plan, do not include this statement. Describe the difference between the waiver coverage and the State plan coverage.
- If skilled nursing services are covered under the waiver only on an "extended State plan service" basis (e.g., the services furnished differ from the State plan coverage only in amount, duration, and frequency, but not scope), employ the following alternate service core service definition:

Core Service Definition *(Extended State Plan Service)*

Services that are provided when nursing services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not otherwise differ from nursing services furnished under the State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is as follows:

Guidance

- Skilled nursing is the provision of nursing services on an intermittent or part-time basis. "Private duty nursing" (see below) entails the provision of nursing services on a continuous or full time basis.
- Skilled nursing services that can be furnished under the State plan should be furnished as expanded EPSDT benefits to waiver participants under age 21.

9. Private Duty Nursing

Core Service Definition:

Individual and continuous care (in contrast to part-time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to a participant at home.

Instructions

- If private duty nursing services are limited to specific types of nursing services, specify the types of services in the definition.
- When private duty nursing services are covered under the State plan but the waiver coverage is different, include the following statement in the service definition: *"Private duty nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from private duty nursing services in the State plan."* Also specify the differences between the waiver coverage and the State plan coverage. If private duty nursing services are not covered under the State plan, do not include this statement. Describe the difference in waiver coverage and State plan coverage.
- If private duty nursing services are covered under the waiver only on an "extended State plan service" basis (e.g., the services furnished differ from the State plan coverage only in amount, duration and, frequency but not otherwise), employ the following alternate service core service definition:

Core Service Definition *(Extended State Plan Service)*

Services that are provided when the limits of private duty nursing furnished under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from private duty nursing services furnished under the State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is as follows:

Guidance

- As defined at 42 CFR §440.80, private duty nursing is the provision of nursing services on a continuous or full-time basis. "Skilled nursing" is the provision of nursing services on a periodic or intermittent basis.
- Private duty nursing services that can be provided under the State plan should be furnished to waiver participants under age 21 as expanded EPSDT benefits.

10. Adult Foster Care

Core Service Definition

Personal care and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under State law)) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including participants served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed [insert number]. Separate payment is not made for homemaker or chore services furnished to a participant receiving adult foster care services, since these services are integral to, and inherent in, the provision of adult foster care services.

Payments for adult foster care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult foster care services does not include payments made, directly or indirectly, to members of the participant's immediate family. The methodology by which the costs of room and board are excluded from payments for adult foster care is described in Appendix I.

Instructions

- Modify or supplement the core definition to reflect the scope of adult foster care furnished under the waiver.
- In the core definition, insert the total maximum allowable number of individuals who may reside in the principal caregiver's home.

11. Assisted Living

Core Service Definition

Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to waiver participants who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety, and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with the assisted living provider.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not to be made for 24-hour skilled care. FFP is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5.

Instructions

- Modify or supplement the core definition to reflect the scope of assisted living services furnished under the waiver.
- Indicate whether payment for assisted living services includes any of the following:
  - Home health care
  - Physical therapy
  - Occupational therapy
  - Speech therapy
  - Medication administration
  - Intermittent skilled nursing services
  - Transportation specified in the service plan
  - Periodic nursing evaluations
  - Other specified services
- When assisted living services are furnished in living arrangements subject to §1616(e) of the Social Security Act (the Keys Amendment), the standards for such services must address the topics specified in Appendix C-2 (item C-2-c-ii), including assuring that the living arrangement is homelike rather than institutional in character.

Guidance

- Payment for assisted living services may encompass a comprehensive array of services and supports that are normally furnished on an integrated basis by an assisted living

provider to residents.

- When the scope of assisted living services includes services (e.g., personal care or chore services) that are also covered as distinct services under the waiver, there must be mechanisms that ensure, when such services are included in the comprehensive rate that is paid to the assisted living provider, the services may not also be billed separately.
- When a comprehensive payment is made to a provider for assisted living services, the provider's own employees must directly furnish some or all services to residents. The provider may arrange for the provision of some services on a contractual basis.
- The scope of assisted living services may include services that may be offered through the State plan to the extent such services are normally furnished as part of a comprehensive array of on-site assisted living services. There must be mechanisms to ensure that, when such services are included in the comprehensive rate that is paid to the assisted living provider, the services may not also be billed separately as State plan services.

12. Chore Services

Core Service Definition:

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.

Instructions

Supplement or modify the core definition as appropriate to reflect covered service elements/ tasks under the waiver.

13. Adult Companion Services

Core Service Definition:

Non-medical care, supervision, and socialization, provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry, and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan.

Instructions

- Supplement or modify the core definition, as appropriate, to reflect the specific covered service elements under the waiver.
- When the waiver also covers personal care, chore, and/or homemaker services, the definition must describe how the provision of adult companion services does not duplicate the provision of such services.

14. Training and Counseling Services for Unpaid Caregivers

Core Service Definition:

Training and counseling services for individuals who provide unpaid support, training, companionship, or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship, or support to a person served on the waiver. This service may not be provided in order to train paid caregivers. Training includes instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the participant. All training for individuals who provide unpaid support to the participant must be included in the participant's service plan.

Instructions

Modify or supplement the core definition to reflect the specific types of training furnished that is furnished to unpaid persons who support the participant.

Guidance

- Training furnished to persons who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the service plan.
- Counseling similarly must be aimed at assisting unpaid individuals who support the participant to understand and address participant needs.
- FFP is available for the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the service plan. FFP is not available for the costs of travel, meals, and overnight lodging to attend a training event or conference.

15. Consultative Clinical and Therapeutic Services

Core Service Definition:

Clinical and therapeutic services that assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, that are not covered by the Medicaid State Plan, and that are necessary to improve the individual's independence and inclusion in their community. Consultation activities are provided by professionals in psychology, nutrition, counseling and behavior management. The service may include assessment, the development of a home treatment/ support plan, training and technical assistance to carry out the plan and monitoring of the individual and the provider in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Instructions

Modify or supplement the core definition to reflect the specific types of consultative services

that are furnished.

Guidance

The purpose of consultative services is to improve the ability of unpaid caregivers and paid direct support staff to carry out therapeutic interventions.

16. Individual Directed Goods and Services

Core Service Definition:

Individual Directed Goods and Services are services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant's safety in the home environment; AND, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. Individual Directed Goods and Services are purchased from the participant-directed budget. Experimental or prohibited treatments are excluded. Individual Directed Goods and Services must be documented in the service plan.

Instructions

Modify or supplement the core definition to reflect the scope of individual directed goods and services in the waiver.

Guidance

- The coverage of this service permits a State to authorize the purchase of goods and services that are not otherwise offered in the waiver or the State plan.
- The coverage of this service is limited to waivers that provide the Budget Authority participant direction opportunity.
- Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of FFP for waiver services, including the prohibition against claiming for the costs of room and board.
- The specific goods and services that are purchased under this coverage must be documented in the service plan.
- The goods and services that are purchased under this coverage must be clearly linked to an assessed participant need established in the service plan.

17. Bereavement Counseling

Core Service Definition

Counseling provided to the participant and/or family members in order to guide and help them cope with the participant's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the participant and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing

premature and otherwise unnecessary institutionalization. Bereavement activities and opportunities for dialog offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment, thereby potentially decreasing complications for the family after the child dies. Bereavement counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to 6 months.

Instructions

Modify or supplement the core definition to reflect the scope of bereavement counseling in the waiver.

Guidance

- Bereavement counseling services are associated with waivers that target children with terminal illnesses.
- Payment for bereavement counseling services may be provided for on-going counseling to family members after the child's death so long as such services were initiated prior to the child's death. The expected costs of such counseling must be billed in advance.

C. Extended State Plan Services

Discussion

When a service is included as an extended State plan service, the coverage parameters (e.g., nature of the service and provider qualifications) contained in the State plan apply. The coverage of a State plan service on an extended basis means providing the service in an amount over and above that permitted under the State plan (e.g., if the plan limits physician visits to three per month, extended coverage may permit additional visits). When a service is defined in a fashion that is different from the coverage under the State plan, it is considered an "other service" that is separately defined in the application. Services that could be covered under the State plan but which are not are considered "other services" for the purpose of the waiver application.

Extended State Plan Services

The following core service definition may be employed for each extended State plan service included in the waiver:

Core Service Definition:

Services that are provided when the limits of [State plan service] under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from [State plan service] services furnished under the State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is as follows: (specify)

Instructions

- Insert the name of the specific State plan service that is offered on an extended basis under the waiver. Extended State plan services may include, but are not limited to:
  - Physician services

- Home health care services
- Physical therapy
- Occupational therapy
- Speech, hearing and language services
- Prescribed drugs, except drugs furnished to participants who are eligible for Medicare Part D benefits
- Dental services
- Other services specified by the State

- For each extended State plan service, specify the extent of the extended coverage (e.g., the provision of additional therapeutic treatments over and above the amount allowed in the State plan).

D. Services in Support of Participant Direction

Discussion

Services in Support of Participant Direction are offered whenever a waiver affords participants the opportunity to direct some or all of their waiver services. Two core service definitions are provided: (a) information and assistance in support of participant direction and (b) financial management services. States may propose additional types of supportive services.

1. Information and Assistance in Support of Participant Direction (Supports Brokerage)

Core Service Definition:

Service/function that assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing, and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the service plan. This service does not duplicate other waiver services, including case management.

Instructions

Modify or supplement the core definition to accurately reflect the scope and nature of supports for participant direction furnished under the waiver

Guidance

- This service is limited to participants who direct some or all of their waiver services.
- As discussed in the instructions for Appendix E (Participant Direction of Services), the scope and nature of this service hinges on the type and nature of the opportunities for participant directly afforded by the waiver.
- Through this service, information may be provided to the participant about:

- Person-centered planning and how it is applied;
- the range and scope of individual choices and options;
- the process for changing the plan of care and individual budget;
- the grievance process;
- risks and responsibilities of self-direction;
- freedom of choice of providers;
- individual rights;
- the reassessment and review schedules; and,
- such other subjects pertinent to the participant and/or family in managing and directing services.

Assistance may be provided to the participant with:

- defining goals, needs, and preferences, identifying and accessing services, supports, and resources;
- practical skills training (e.g., hiring, managing, and terminating workers, problem solving, conflict resolution)
- development of risk management agreements;
- development of an emergency back-up plan;
- recognizing and reporting critical events;
- independent advocacy, to assist in filing grievances and complaints when necessary; and,
- other areas related to managing services and supports.

- This service may include the performance of activities that nominally overlap the provision of case management services. In general, such overlap does not constitute duplicate provision of services. For example, a "support broker" may assist a participant during the development of a person-centered plan in order to ensure that the participant's needs and preferences are clearly understood even though a case manager is responsible for the development of the service plan. Duplicate provision of services generally only arises when exactly the same activity is performed and billed on behalf of a waiver participant. Where the possibility of duplicate provision of services exists, the participant's service plan should clearly delineate responsibilities for the performance of activities.

2. Financial Management Services

Core Service Definition:

Service/function that assists the family or participant to: (a) manage and direct the disbursement of funds contained in the participant-directed budget; (b) facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding Federal, State, and local tax, and making tax payments to appropriate tax authorities; and, (c) performing fiscal accounting and making expenditure reports to the participant or family and State authorities.

Instructions

Supplement or modify the core definition to accurately reflect the scope and nature of financial management services furnished under the waiver.

Guidance

- This service is limited to participants who direct some or all of their waiver services.
- As discussed in the instructions for Appendix E (Participant Direction of Services), the scope and nature of this service hinges on the type and nature of the opportunities for the participant to direct afforded by the waiver. In general, the functions that may be performed in conjunction with the provision of financial management services include (but are not necessarily limited to):

  Employer Authority

  - Assist the participant to verify worker citizenship status
  - Collect and process timesheets of support workers
  - Process payroll, withholding, filing, and payment of applicable Federal, State and local employment-related taxes and insurance

  Budget Authority

  - Maintain a separate account for each participant's participant-directed budget
  - Track and report participant funds, disbursements, and the balance-of participant funds
  - Process and pay invoices for goods and services approved in the service plan
  - Provide participant with periodic reports of expenditures and the status of the participant-directed budget

  Additional Functions/Activities

  - Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
  - Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
  - Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
- When financial management services are provided as a waiver service, entities that perform these services may be deemed by the State to function as an Organized Health Care Delivery System.
- When entities are not deemed to be an Organized Health Care Delivery System, such entities must have a written agreement with the Medicaid agency in order to execute and hold Medicaid provider agreements and receive and disburse funds.
- When financial management services are furnished as a waiver service, the number of providers may not be limited.
- The waiver may provide that entities which furnish financial management services undergo a readiness review as part of the determination that such entities are qualified to furnish these services.